IN THE UNITED STATES COURT
NORTHERN DISTRICT OF OHIO
EASTERN DIVISION

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IN RE: NATIONAL PRESCRIPTION OPIATE LITIGATION

MDL NO. 2804

Case no.
17-md-284
Judge Dan Polster

This document relates to:
The County of Summit, Ohio, et al.,
V.
Purdue Pharma L.P., et al.,
Case No. 1:18-OP-45090 (N.D. Ohio)

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Videotaped deposition of
DONNA SKODA
August 14, 2018
9:06 a.m.

Taken at:
Brennan Manna & Diamond
75 East Market Street
Akron, Ohio
Wendy L. Klauss, RPR

APPEARANCES:

On behalf of the City of Akron, Summit County, and the Witness:
Motley Rice LLC
ANNE McGINNESS KEARSE, ESQ.
HANNA S. WERNER, ESQ.
JODI FLOWERS, ESQ.
28 Bridgeside Boulevard
Mt. Pleasant, SC 29464
(843) 216-9140
Akearse@motleyrice.com
Hwerner@motleyrice.com
Jflowers@motleyrice.com
-AND-
FIDELMA L. FITZPATRICK, ESQ.
55 Cedar Street, Suite 100
Providence, RI 02903
(401) 457-7728
Ffitzpatrick@motleyrice.com

On behalf of Cuyahoga County:
Napoli Shkolnik PLLC
JOSEPH L. CIACCIO, ESQ.
400 Broadhollow Road, Suite 305
Melville, NY 11747
(631) 224-1133
Jciaccio@napolilaw.com
-AND-
Plevin & Gallucci
ROBIN M. WILSON, ESQ.
55 Public Square, Suite 2222
Cleveland, OH 44113-1901
(216) 861-0804
Rwilson@pglawyer.com

On behalf of Johnson & Johnson and Janssen Pharmaceuticals, Inc.:
Tucker Ellis, LLP
TARIQ M. NAEEM, ESQ.
GIUSEPPE W. PAPPALARDO, ESQ.
950 Main Avenue, Suite 1100
Cleveland, OH 44113
(216) 592-5000
Tariq.naeem@tuckerellis.com
Gwp@tuckerellis.com

APPEARANCES, Continued:

On behalf of the Allergan:
Kirkland & Ellis LLP
ZACHARY A. CIULLO, ESQ.
300 North LaSalle
Chicago, IL 60654
(312) 862-2000
Zac.ciullo@kirkland.com

On behalf of Distributor AmerisourceBergen Drug Corporation
Reed Smith, LLP
MICHAEL J. SALIMBENE, ESQ.
Three Logan Square
1717 Arch Street, Suite 3100
Philadelphia, PA 19103
(215) 851-8100
Msalimbene@reedsmith.com

On behalf of Rite Aid of Maryland:
Morgan Lewis
JOHN P. LAVELLE, JR.
1701 Market Street
Philadelphia, PA 19103-2921
(215) 963-4842
John.lavelle@morganlewis.com

On behalf of Cardinal Health, Inc.:
Williams & Connolly LLP
JOSHUA D. TULLY, ESQ.
725 Twelfth Street, N.W.
Washington, DC 20005
(202) 434-5000
Jtully@wc.com

On behalf of Prescription Supply, Inc.:
Pelini, Campbell & Williams, LLC
GIANNA M. CALZOLA-HELMICK, ESQ.
Bretton Commons
8040 Cleveland Avenue NW, Suite 400
North Canton, OH 44720
(330) 305-6400
Giannac@pelini-law.com

APPEARANCES, Continued:

On behalf of Endo Health Solutions, Inc, and Endo Pharmaceuticals Inc.
Arnold & Porter
ANGEL TANG NAKAMURA, ESQ.
777 South Figueroa Street, 44th Floor
Los Angeles, CA 90017-5844
(213) 243-4000
Angel.nakamura@arnoldporter.com

On behalf of Walmart Inc.:
Jones Day
LISA GATES, ESQ.
North Point
901 Lakeside Avenue East
Cleveland, OH 44114-1190
(216) 586-3939
Lgates@jonesday.com

Oh behalf of HBC Service Company:
Marcus & Shapira, LLP
ZACHARY P. FENSTEMAKER, ESQ.
One Oxford Centre, 35th Floor
301 Grant Street
Pittsburgh, PA 15219-6401
(412) 471-3490
Fenstemaker@marcus-shapira.com

On behalf of Distributor Defendant McKesson Corporation:
Covington & Burling LLP
STEPHEN RAIOLA, ESQ.
One CityCenter
850 Tenth Street, NW
Washington, DC 20001-4956
(202) 662-6000
Sraiola@cov.com

On behalf of Miami Luken:
Jackson Kelly PLLC
SAMANTHA M. D'ANNA
500 Lee Street East, Suite 1600
P.O. Box 1600
Charleston, WV 25301
(304) 340-1141
Samantha.danna@jacksonKelly.com

APPEARANCES, Continued:

On behalf of Insys Therapeutics, Inc.
Holland & Knight LLP
JOE FRANCO, ESQ.
2300 U.S Bancorp Tower
111 S.W. Fifth Avenue
Portland, Or 97204
(503) 517-2941
Joe.franco@hklaw.com

On behalf of CVS Rx Services, Inc. and CVS Indiana, LLC:
Zuckerman Spaeder LLP
ANTHONY RUIZ, ESQ.
1800 M Street, NW
Suite 1000
Washington, DC 20036-5802
(202) 778-1823
Aruiz@zuckerman.com

On behalf of Teva Pharmaceutical Industries Ltd.
Morgan Lewis, LLP
ELLIOTT E. BROWN, ESQ,
1111 Pennsylvania Avenue N.W.
Washington, DC 20004
(202) 739-3000
Elliott.brown@morganlewis.com

On behalf of Mallinckrodt LLC.
Ropes & Gray
HAYDEN MILLER, ESQ.
1211 Avenue of the Americas
New York, NY 10036
(212) 596-9451
Hayden.miller@ropesgray.com

Also Present:
Joseph Vandetta, Videographer

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THE VIDEOGRAPHER: The date is August 14, 2018. The time is 9:06 a.m. The caption of this case is In Re: National Prescription Opiate Litigation. The name of the witness is Donna Skoda.

At this time the attorneys present and those attending remotely will identify themselves and the parties they represent.

MS. KEASE: Anne Kearse, on behalf of Summit County and Akron.

MS. FITZPATRICK: Fidelma Fitzpatrick, on behalf of Summit County and Akron.

MS. WERNER: Hannah Werner, on behalf of Summit County and Akron.

MS. WILSON: Robin Wilson, of Plevin & Gallucci, on behalf of Cuyahoga County.

MR. CIULLO: Zach Ciullo, for Allergan on behalf of -- from Kirkland Ellis, on behalf of Allergan.

MS. NAKAMURA: Angel Nakamura, Arnold & Porter, on behalf of Defendants Endo Pharmaceuticals and Par.

MS. CALZOLA-HELMICK: Gianna

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Calzola-Helmick, from Pelini, Campbell & Williams, on behalf of Prescription Supply, Inc.

MR. FENSTEMAKER: Zach Fenstemaker, with Marcus & Shapira, on behalf HBC Service Company.

MR. TULLY: Josh Tully, from Williams & Connolly, on behalf of Cardinal Health.

MR. LAVELLE: John Lavelle, from Morgan Lewis, on behalf of Rite Aid of Maryland.

MR. SALIMBENE: Mike Salimbene, from Reed Smith, for AmerisourceBergen Medical Group.

MR. PAPPALARDO: Giuseppe Pappalardo, with Tucker Ellis, on behalf of Johnson & Johnson.

MR. NAEEM: Tariq Naeem, Tucker Ellis, on behalf of Janssen Pharmaceuticals and Johnson & Johnson.

Can the people on the phone please identify themselves.

MR. RAIOLA: Stephen Raiola, with Covington & Burling, on behalf of McKesson.

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MR. NAEEM: Anybody else? Just a reminder that everybody on the phone, regardless who they are and who they represent, has to represent themselves per the deposition protocol entered by the judge. So it looks like we have a few more people, please identify yourself. Okay.

THE VIDEOGRAPHER: Would the court reporter please swear in the witness.

DONNA SKODA, of lawful age, called for examination, as provided by the Statute, being by me first duly sworn, as hereinafter certified, deposed and said as follows:

EXAMINATION OF DONNA SKODA

BY MR. NAEEM:

Q. Good morning.

A. Good morning.

Q. Would you identify yourself please for the record.

A. My name is Donna Skoda, S-K-O-D-A.

Q. Thank you, Ms. Skoda, for being here today. As we identified ourselves shortly before you were sworn, my name is Tariq Naeem, I'm going to be examining you today.

Before we get started, I just want

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to lay down a few ground rules to make this easier, primarily for the court reporter. Let me ask, have you been deposed before?
A. Yes.
Q. In your work capacity?
A. Yes.
Q. When was the last time you were deposed?
A. Probably three years ago.
Q. And I don't want to get into the specifics, but generally what kind of case was it?
A. It was a wrongful termination employment case.
Q. And have you been deposed other than that instance?
A. No.
Q. Did you testify at trial in that case?
A. No.
Q. Well, just briefly, what I want to make sure again, and this is for the court reporter's benefit, is that you verbalize your answers, yeses and nos, or whatever you need to say, but no nods and shrugs or --

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A. Right.
Q. -- ambiguous language like uh-huh and uh-uh, which makes sense to us here, but won't translate on the record. I'm going to ask, again because we are used to conversational speak, but again the court reporter has difficulty taking down what we are both saying, if we are talking at the same time, that I would ask if you let me finish my question, and I'll give you the courtesy of finishing your answer before I move on to the next question.
A. Okay.
Q. And then if I ask bad questions, which will be frequent over the course of the day, if it doesn't make sense, let me know, and I'll try to rephrase it. In my head it makes sense, it doesn't come out the way I want all the time. So I don't want you trying to interpret what you think I meant, just let me know and I'll rephrase it, okay?
A. Uh-huh. Thank you.
Q. And if you want to take a break at any point, just let us know, and we will go off the record.

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As we get started, I want to start with your background, but before we do, let me ask, I assume you prepared for your deposition today?
A. Yes.
Q. How many times -- well, let me ask. Did you meet with counsel to prepare for deposition?
A. Yes.
Q. How many times have you met in total to prepare for your deposition today?
A. Twice.
Q. When was the first time you met with counsel to prepare?
A. It was a while ago, maybe a week or two.
Q. How long did you meet to prepare for that -- for the deposition that first time?
A. I think that was maybe four or five hours.
Q. And then there was a second meeting --
A. Correct.
Q. -- to prepare?
A. Yes.

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Q. When was that?
A. Yesterday.
Q. And how long did you spend preparing for the deposition?
A. Four hours, five.
Q. Now, as I ask my questions here, I don't want you to tell me anything about what you spoke with your attorneys. That is privileged. So if it comes out that way, I'm not asking for that information.
Did you review documents to prepare for your deposition?
A. Yes, documents that we submitted.
Q. That were produced by Summit County?
A. Uh-huh.
Q. Specifically by Summit County Public Health?
A. Uh-huh.
Q. Let's talk about that a little bit, not the documents you reviewed, but the documents your agency collected, and to be clear, you are the health commissioner for Summit County Public Health, correct?
A. Correct.

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Q. When did you become aware that a lawsuit was going to be filed?
A. Let me think. There was sort of conversation in the City of Akron. We merged health districts, and they no longer had their records. They were asking us for some financial information, probably in mid 17, 2017.
They were asking us for some financial information, but at that time, we really didn't know what they wanted it for. After that, we were invited to a meeting.
MS. KEARSE: And I'm just going to object to anything that was discussed with counsel in regards to the lawsuit. That is privileged, and we don't need to talk about that.
A. We were just invited to the meeting about the general lawsuit with the county.
Q. And do you recall when that meeting was?
A. It had to have been in the fall of 2017 maybe, or maybe earlier.
Q. And again, as your counsel pointed out, we are not allowed to ask about the

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conversations you had with counsel present, but can I ask, was counsel present for that meeting?
A. There was a representative there, but it was not any of these ladies.
Q. Was it a representative of an outside law firm?
A. Yes.
Q. Was there anybody present from the Summit County Law Department?
A. Yes. Wait. Law department, yeah, John Galonski, yes.
Q. And anybody there from the City of Akron Law Department?
A. Yes.
Q. And I understand there were a number of other municipalities --
A. Correct.
Q. -- that were involved early in the lawsuit. Were they represented at this meeting as well?
A. Yes, but I couldn't tell you if they were all law directors though.
Q. And just to capture what I think I heard from you about the timing of all this,

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was that in mid 2017, Akron had reached out to you or your agency for some financial information?
A. Correct.
Q. And that the meeting with the representatives of the plaintiffs and counsel, outside counsel, was later, it was after that, you think in the fall of 2017?
A. I think, yeah.
Q. Now, prior to mid 2017, had you attempted to collect any documents related to what I'm going to refer to throughout the course of the day today as the opioid crisis, for the purposes of litigations?
A. No, no.
Q. So again, mid 2017 is the first time --
A. I can remember, yeah.
Q. And to be clear, you didn't undertake to -- any document identification or collection activities prior to Akron reaching out to you?
A. Uh-huh.
THE NOTARY: I'm sorry?
A. I said no. I'm sorry.

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Q. I want to follow up very quickly on -- you mentioned Akron used to have its own health department --
A. Correct.
Q. -- and then there was a merger?
A. Right.
Q. Give me just a quick background of when that was?
A. Actually, in Summit County, the three health -- there is two city health departments and a county health department. It would have been in October of 2010 we picked up -- the City of Barberton Health Department joined, and then in January of 2011, we picked up Akron Health Department. So we became one combined general health district.
Q. And so your testimony earlier was that when you were contacted by Akron in mid 2017, can you let me know who it was specifically who contacted you?
A. Yeah, if I could think of his name. One of their attorneys, Isham.
MS. KEARSE: And I'm going to object if this is an attorney communications with that.

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MR. NAEEM: And the identity of the person, can we just ask about the identity of the person?
A. I'd have to think of his name, but I --
Q. That's his first name?
A. I think it was Isham.
Q. But it was somebody from the Akron Law Department --
A. Correct.
Q. -- to your knowledge, that contacted you?
A. Correct. Well, I should say that was after. Initially, that request came to our fiscal officer to collect information about costs, and then he followed up with me, to ask if we could do it.
Q. Who is the fiscal officer?
A. Angela Burgess.
Q. Angela Burgess?
MS. KEARSE: Again, if those were communications by a lawyer or counsel, that that is privileged.
Q. And the fiscal officer, Angela Burgess, is that a Summit County position or is

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that a Summit County Public Health position?
A. Summit County Public Health position.
Q. So someone from Akron reaches out to Ms. Burgess, and then is that in mid 2017 time frame we are still talking about?
A. Yeah. I think it was, yeah.
Q. Do you recall when the lawsuit was filed?
A. I want to say November, December of 2017, maybe.
Q. And prior to the lawsuit being filed -- well, strike that. Let me ask it again.
Between mid 2017, the first time you were notified about the lawsuit, until that November, December 2017 time frame when the lawsuit was filed, and I have it here, we can show you the date, it's not important at this point, but if you want to look at it, let me know, did you undertake to collect any documents regarding the opioid crisis?
A. No.
Q. When was the -- when was the first time -- well, strike that.

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Were you the -- were you the person at Summit County Public Health that was responsible for ensuring that employees of that agency were maintaining emails for the lawsuit?
A. I'm not sure I understand what you are saying.
Q. Let me --
A. We have a record retention policy.
Q. That's something that has been in effect --
A. Oh, yeah.
Q. -- prior to you?
THE NOTARY: Let him finish the question, please.
Q. How long has that record retention policy, the current version in effect, how long has that been in effect?
A. Since, well, five, six years at least. The records, I'm trying to -- they did change the rules for record retention in the State of Ohio, having a records commission, and that was probably five or six years ago.
Q. So the change in the State of Ohio policy dictated the current version that's in effect?

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A. Uh-huh.
Q. And that's dictated to your agency by State of Ohio law?
A. Yes.
Q. Do you recall what that change was five or six years ago?
A. No.
Q. Are you familiar with the record retention policy generally?
A. Yes.
Q. Do you know how long emails are to be maintained?
A. No.
Q. Do you know generally, is there any time requirement with respect to records, any records, are to be maintained?
A. Yes. It depends on what they are. Some are 50 years, some are until the child turns 21. They are -- we have a records schedule, and they are all maintained according to that.
Q. Financial records, do you know how long those are to be maintained?
A. Seven years.
Q. And what was Summit County's policy

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prior to this revision with respect to financial records being maintained, do you recall?
A. Yes. We kept everything.
Q. So, and I'm assuming you use that kind of euphemistically, but basically --
A. We just kept everything and didn't get rid of anything until we were told we were allowed to establish a schedule and start getting rid of.
Q. All right. And so was that that five or six years ago that now you had that policy that some things would be allowed to be destroyed and some things would continue to have to be maintained pursuant to that schedule?
A. Correct. We got clarification on what that was.
Q. Did Summit County Public Health maintain those records, and I want to go through the list a little bit, but with respect to financial, for example, were those maintained electronically or in hard copy?
A. Both.
Q. The hard copy, were they maintained

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on site or were they sent out for storage?
A. On site.
Q. Do you know if those records still resist -- I'm sorry, still exist?
A. Some do, others have been destroyed.
Q. And how far back do those records go currently, the existing records?
A. It depends on what record it is. We are required to keep air monitoring records for, I think, a hundred years, so some of them are very old.
Q. So let's just -- let's just right now talk about the financial records, which you told me are now currently required to be maintain for seven years?
A. I believe seven years.
Q. So certainly Summit County Public Health is maintaining seven years of financial records?
A. Yes.
Q. Are you maintaining records that go further back then seven years?
A. I couldn't be sure about that.
Q. Where would those records be if

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they were maintained, if those --
A. 1867 West Market Street.
Q. Is that Summit County's headquarters --
A. Our public health.
Q. -- public health headquarters?
A. Yes.
Q. Who would you talk to within your agency to look for and identify those records?
A. Stephen Nemecek.
Q. Can you spell the last name.
A. N-E-M-E-C-E-K.
Q. And what is his title with Summit County Public Health?
A. He is actually a paralegal, and he does our record retention.
Q. So would he be the person you would speak to regarding any category of records with respect to do they exist and where are they?
A. Yes.
Q. How long has he been with Summit County Public Health?
A. Three years, four years maybe.
Q. And was he hired specifically with respect -- strike that.

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At the time he was hired, record retention, was that one of the things that he were responsible for from the date of hire?
A. No, it was not.
Q. Was there somebody else prior to Mr. Nemecek who was responsible for the record retention?
A. It was sort of -- it was administration that handled it, all of the records that were retained, but I don't believe there was a specific person.
Q. And again, administration for Summit County Public Health?
A. Correct.
Q. Which is kind of a group under the umbrella that you are responsible for the administration?
A. Yes.
Q. I want to call it department, but I don't want to use a word that doesn't actually appear --
A. Yes.
Q. -- on an org chart?
A. Administration.
Q. Who would you go to at Summit

County Public Health administration if you had questions regarding records retention that preceded Mr. Nemecek's employment?

A. Heather Pierce, P-I-E-R-C-E.

Q. Now, when you were advised of the lawsuit in 2017, and when you were ultimately asked to identify and collect documents for the litigation, did you work with Mr. Nemecek and Mr. Pierce for that purpose?

A. Yes. Well, it was Stephen, and Heather is the girl, Heather Pierce, and our attorney, and also Brenda Pickle, who is my administrative assistant, and our IT individual, Eddie Mink.

Q. Okay. When did you direct Mr. Nemecek, Ms. Pierce, Mr. Mink, Ms. Pickle to begin collecting documents for this litigation?

A. When we received the request.

THE VIDEOGRAPHER: Off the record?

MR. NAEEM: Yes. Let's go off the record.

THE VIDEOGRAPHER: Off the record at 9:26.

(Pause.)

THE VIDEOGRAPHER: On the record, 9:27.

Q. Ms. Skoda, we took a very, very short break off the record, and what we were talking about before we did was Summit County Public Health's collection of records for the lawsuit, and you had identified a number of names of folks who were involved in those efforts from your agency.

MS. KEARSE: I'm going to just object. I don't think it was specific to the lawsuit. You were asking general questions about record retention.

Q. My question had been, shortly before we went on the break, was when did you have these folks begin collecting records, and you said it was when you got the request.

A. Correct, because we --

Q. Well, I was going to ask, when was that request?

A. I'm not 100 percent sure. I'm going to say early 18.

Q. And again, I don't want to know anything about the contents of the communication. I just want to know, was that

request sent to you by outside counsel?

A. After we signed a contract and hired them, yes.

Q. And the contract was signed when?

A. January, February.

Q. And again, just to be clear so the record is clear, that was a contract with your outside counsel to represent Summit County in this lawsuit?

A. Summit County Public Health, correct.

Q. And which law firm was it you signed the contract with?

A. I think there was -- it was a group. I was Motley Rice, with a subsidiary of Brennan Diamond helping locally.

Q. So you signed a contract, there is a request to collect documents, and then you meet with some of the names we talked about to go ahead and collect documents, yes?

A. Yes.

Q. One of the things -- well, strike that. Let me ask it.

Did you collect financial records, and when I say you, I mean your agency, or at

your direction, were financial records collected?

A. Yes.

Q. And as we sit here today, do you know whether there were records that were -- financial records that were collected that are older than seven years old?

A. No.

Q. You don't know?

A. I don't know.

Q. Was budget information for Summit County Public Health one of the things you asked for?

A. Yes, but let me -- I want to clarify a minute. We were asked for the budget information for the City of Akron. We then collected additional documents that were requested. We dumped all of our emails. Everything we possibly had, we gave up, that we had in our possession, that was of value, I think, to whomever wanted to review it.

I cannot be 100 percent sure that we looked at those financial documents again, once we gave that information.

Q. Okay. So let me see if I

understand what you just said. At some point, you get the request, and you and the folks that work for Summit County Public Health go looking for what has been asked for?

A. Correct.

Q. You don't specifically review those documents to see should I or shouldn't I produce it, you just give them whole categories of documents?

A. Correct.

Q. So one of those categories is financial records, but you don't know specifically what is contained in those documents that were produced?

A. Correct.

Q. The financial documents, were they hard copy, were they electronic, were they both?

A. Probably both.

Q. With respect to employees of Summit County Public Health, were there -- were you responsible for identifying people who would have some knowledge about this opioid crisis and collecting their electronic or hard copy documents?

A. Jackie Pollard, P-O-L-L-A-R-D, is our assistant director for our alcohol and other drug services. So Jackie was involved with collecting any information that was, should I say, treatment or programmatically focused.

Q. How long has Jackie, Ms. Pollard, been employed by Summit County Public Health?

A. About a year.

Q. Who was her predecessor?

A. Yvette Edwards. Common spelling.

Q. And how long was she in that position, Ms. Edwards?

A. Two years, two to three years.

Q. Is she still employed, in any capacity, by any Summit County government entity?

A. No.

Q. Do you know, does she still live in the area?

A. I am not sure, to be quite honest with you.

Q. Have you spoken with her about this lawsuit?

A. No.

Q. Do you know who was Ms. Edward's predecessor?

A. Carol Boze, and I believe it is B-O-S-E, or it might be Z.

Q. And how long did Ms. Boze have the position prior to Ms. Edwards?

A. Well, I don't know that, because that's when the merger happened, and she came over with the merger. So she was probably employed by us for about a year or two, and then she retired. Prior to service at Akron, I don't know.

Q. If you had to try to get employment records for folks that were with Akron prior to the merger, who would you talk to?

A. City of Akron personnel.

Q. Is there anybody in particular you would call?

A. Unfortunately, they have all retired. I don't know anyone there now.

Q. So going back to the collection of documents, Ms. Pollard, who is the assistant director of alcohol and other drug services, so if I say AOD --

A. Yes.

Q. -- services; is that accurate?

A. Yes.

Q. Ms. Pollard, who is an assistant director of AOD services, you relied on her to identify the people and programs who would have relevant information to this lawsuit?

A. Correct.

Q. And did you supervise her in any way or just tell her, explain it to her and tell her to take responsibility for it?

A. She completed that task. I did not direct her work.

Q. Did she communicate directly with the lawyers then, with respect to what existed -- and this is to your knowledge, what existed and what needed to be produced?

A. No. Actually, we compiled everything and then submitted it as one, sort of, pile, big pieces of information.

Q. And that pile you turned over, was some of it electronic and some of it hard copy?

A. I believe so.

Q. In addition to financial records, do you know whether any records, any patient-specific records were collected and

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turned over?
A. Not to my knowledge.
Q. Now, Summit County Public Health does provide some services to clients, to patients? I don't know what word you would be comfortable using but --
A. Yes.
Q. And I want to focus this deposition as much as possible just on substance abuse, generally, and opioids specifically. So, you know, child services or anything else, that doesn't relate to -- I'm going to try not to ask about that, otherwise, we would be here forever, right? I know Anne would love to be here forever, but we are going to try to keep it narrow.
MS. KEARSE: I have been here forever.
MR. NAEEM: We're just getting started.
Q. Are there clients or patients that Summit County Public Health provides substance abuse services to?
A. Yes.
Q. And what are those services?

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A. We have intensive outpatient treatment, we have counseling, we have education classes, services, we also provide naloxone training, needle exchange, medication-assisted treatment, only with Vivitrol. We don't use Suboxone at all.
And we also address some of their social needs, by trying to make sure they have housing and food, we do vaccine, we do communicable disease testing, HIV, hep C.
Q. And with respect to, again, collection of documents, Ms. Pollard would have been the person responsible for identifying what documents, perhaps, in these services should be collected and produced?
A. Correct.
Q. Just following up on a few of the things you mentioned with respect to the patient-specific services, are any of those services contracted out, or are those all performed by Summit County Public Health?
A. They are all provided by us. The only contract in any of that is we do have a contract nurse practitioner, but she works for Summit County Public Health.

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Q. That's more of an employment --
A. Correct. It is it is an employment relationship.
Q. Sure. You said with respect to the medication-assisted treatment, I noted you said you don't use Suboxone. How long has that medication-assisted treatment program been in existence with Summit County Public Health?
A. Six months.
Q. And who designed that program? Is there somebody within Summit County generally, a clinical officer, is it a different department, who is -- who designed that program?
A. We have a medical director. We follow the practice guidelines that are given to us by the alcohol, drug, mental health board, as well as the Ohio State Mental Health Addiction Services. So when we designed that program, we did it in respect, I believe the acronym is OMAS, Ohio State -- but it's the group that sets the criteria to provide medication-assisted treatment.
So it was done, those protocols were established in relationship to best

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practice with our ADM board. They employ a psychiatrist, Doug Smith, and Dr. Smith and Jerry Craig were instrumental in helping us establish that program, clinically.
Q. Jerry Craig is also an ADM's board employee?
A. He is their executive director.
Q. Dr. Smith -- and is it Mr. Craig or Dr. Craig?
A. Mr.
Q. Have they been with the ADM board for at least as long as you have been the health commissioner for Summit County --
A. Yes.
Q. -- Public Health? Okay.
Now, with respect to the medical-assisted treatment, you mentioned that there were some state-level criteria that were used to design that program, there was some consultation with the Summit County ADM board?
A. Correct.
Q. And then you mentioned a medical director. Is that a Summit County Public Health medical director?
A. Yes, our medical director.

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Q. And who is that?
A. Erica Sobolewski, S-O-B-O-L-E-W-S-K-I. Sobolewski.
Q. How long has had she been with Summit County Public Health?
A. Eight months, nine months.
Q. Who was her predecessor?
A. Margo Erme, E-R-M-E.
Q. Dr. Sobolewski, did I pronounce that correct?
A. Yes.
Q. What is her medical specialty, if you are aware?
A. Family practice.
Q. And Dr. Erme, did I pronounce that correctly?
A. Correct.
Q. What was her medical -- or what is her medical specialty?
A. She was an ER physician.
Q. All right. So State of Ohio, ADM board, your medical director were responsible for designing this medical-assisted treatment program which has been in existence for about six months, correct?

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A. Correct.
Q. Why was the decision made not to use Suboxone?
A. We felt, starting out, we needed to start slowly, and start to develop the program, make sure we had good protocols in place, and we were able to be successful with the Vivitrol administration, and then we would move into other medications.
Q. So it's not something that was a refusal --
A. No.
Q. -- to consider Suboxone, it's just part of the normal rollout of this program?
A. Correct.
Q. How many patients, if you are aware, has Summit County Public Health provided services to, medical-assisted treatment services, in the six months the program has been in effect?
A. I believe, in order for us to be certified and to work through the state guidelines, we had to do an initial, sort of, test group of patients, I believe those were somewhere between six and ten, and we completed

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that.
Q. Is there currently, as the program is in effect, is there an outer number of patients that your agency is allowed to provide services to?
A. I'm not sure. An outer number?
Q. Yeah. So if we were to put the funding issues aside and you had unlimited resources, could you provide medical-assisted treatment to any patient who came into the agency for those services?
A. Vivitrol, yes. There are not the restrictions there are on Suboxone.
Q. And Suboxone has the limit on the number of patients that can be treated at one time?
A. Yes.
Q. How many is that for Suboxone?
A. They were talking about raising it in Ohio, but it is not very much. I don't know the exact number now.
Q. Is it somewhere in the 1 to 20 range?
A. Oh, no. I would say it's somewhere between 50 to a hundred.

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Q. So each clinic has a limit on the amount of patients they are able to --
A. Initially --
THE NOTARY: Wait a minute, please. Let him finish the question. "So each clinic has a limit on the number of" --
Q. -- patients that can be treated with Suboxone at any one time?
A. Yes.
Q. But Vivitrol does not have those same restrictions?
A. Correct.
Q. So Summit County Public Health has treated, you said, between six and ten patients?
A. I believe so.
Q. And has -- is there some sort of review before that program can be expanded?
A. No. I think we had to complete those patients, complete the protocols, and then we now can move on.
Q. Beyond that initial set of six to ten patients, has Summit County Public Health provided any medication-assisted treatment to other patients?

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A. I'm not sure.
Q. Is Dr. Sobolewski in charge of administering the program, specifically providing services to the patients?
A. She is the medical director, so she has oversight on that program.
Q. She works with some of the staff from Summit County Public Health?
A. Yes. A nurse practitioner as well as public health nurses.
Q. Now, does Summit County Public Health maintain treatment records for the patients that receive medication-assisted treatment?
A. Yes.
Q. So she treats them just as if they were a patient coming into her private practice office?
A. Correct.
Q. And where does -- Dr. Sobolewski, does she work full time for Summit County Public Health?
A. Part time.
Q. Does she provide treatment at her office, or does she provide for agency

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patients -- does she provide the treatment at her office, or does it happen at one of your clinics?
A. It happens at Summit County Public Health, our clinics.
Q. So with respect to those treatment records, would they be maintained in the files of Summit County Public Health?
A. Yes.
Q. One of the programs you also mentioned was needle exchange.
A. Correct.
Q. Is that -- well, strike that. Let me just ask.
How long has Summit County Public Health been administering that program?
A. I'm going to say at least a year, maybe a little longer. It's when the law changed, and I can't remember exactly when the law changed that allowed public health districts to do syringe exchange programs.
Q. And that is a Summit County Public Health administered program?
A. Yes.
Q. Does Dr. Sobolewski run that

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program?
A. No.
Q. That's done by somebody else at Summit County Public Health?
A. Yes.
Q. Who is responsible for --
A. Jackie Pollard.
Q. And what kind of records does Summit County Public Health maintain regarding that program?
A. Limited. If you're familiar with syringe exchange programs, they are done anonymously. Therefore, everybody is given a patient ID number, and the records that are maintained are all tied to a patient record number, but we have no idea as to the identity of that person, unless they would choose to seek treatment with us, then we may know their identity.
And then, so there is a sign-in sheet and the number of needles returned and given, and that would -- that's about all that we keep.
Q. Is that something that Summit County Public Health employees are trained to

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do, which is offer treatment services?
A. Oh, yes.
Q. And this needle exchange program has been in effect for, you said, a year --
A. Year and a half maybe.
Q. -- a little more maybe?
A. It may have been 16. It may have been 16. They changed the rule. As soon as they changed the rule, we started with it.
Q. Are those services provided at the clinic or clinics, or are there other sites where the needle exchange is done?
A. It has expanded. There is such a need, that we had to go to a second site. So we are now using a second site.
Q. And with respect to the funding for the needle exchange, is that funded entirely through Summit County Public Health revenue or its budget or does it come from outside sources?
A. Both.
Q. Roughly, if you can tell me, what percentage is funded directly by Summit County Public Health and what percentage is funded through outside sources?

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A. I would say probably we have contributed 20 percent, and the rest would be outside sources.
Q. And the outside sources, at least at a general level, I don't need the specifics, if it's a specific foundation or a specific grant name, I don't need to know, but what are the sources of the outside revenue, at a high level?
A. State of Ohio, United Way, as well as the alcohol, drug and mental health board.
Q. Okay. I'm working backwards from the list you gave me. So one of the other services that your agency, you said, provides with respect to substance abuse and/or opioid services is naloxone training?
A. And distribution.
Q. Okay, and I was going to ask that, because I either didn't write it down or you didn't say it. So there are two facets of the naloxone. There is the training for people, how to use, and then there is the distribution of the kits; is that correct?
A. Correct.
Q. Now same question that I asked with

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respect to the needle exchange, how much of the funding for the entire program, whether it is supplies or training, comes from your agency's budget and how much comes from outside sources?
A. Probably, again, it's a small percentage from our budget. I would say 10 to 15 percent, and the remaining amount would be from outside sources.
Q. And those sources are generally the same as the ones you mentioned for the needle exchange program?
A. With the addition of OMAS, Ohio Mental Health and Addiction Services. They have purchased most of the Narcan. They have given the naloxone to us.
Q. How long has the naloxone program, and I want to focus on the distribution of the -- they call them Narcan kits?
A. Yes.
Q. Yeah. How long has Summit County Public Health been distributing those kits?
A. Probably two years.
Q. Currently, is Ms. Pollard also responsible for that program?
A. Yes.

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Q. Does Dr. Sobolewski have any oversight or provide any consultation?
A. Yes. Because it is a prescription medication, she signs the prescriptions.
Q. I assume -- well, strike that.
I'm not going to assume anything, and I'm not even going to ask that question.
How many, if you know, naloxone kits have been distributed by Summit County Public Health in the two years or so that the program has been in existence?
A. I can take a rough guesstimate. About at least over a thousand to 1500, if you include law enforcement.
Q. Does your agency track how many of those have actually been used?
A. Yes. If individuals tell us.
Q. And that would -- individuals being the first responders, or would it be the --
A. Well, not first responders, if you are talking about -- we train only the police. We do not train -- paramedics have their own supply they have used for years.
We give it to police. They do not -- they come back and get refills, we can

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give them additional, and we track that.
We have community members, family members, that will come back and say they used it. So we then get replacement kits. That data we keep.
Q. Is it a situation where you find, and I'm following up, kind of, on the example you gave me, where the same family members are coming in for more kits for the same family member who is abusing opioids?
A. I couldn't honestly say that.
Q. Has there been any situations in the last two years, with respect to the Narcan, that Summit County Public Health has been unable to obtain the amount of kits that it was seeking to distribute?
A. When we first started doing it, it was reasonably priced, and then the price took off. It got a lot more expensive. So we had to look for additional resources to be able to keep purchasing it.
Q. Was there a point in time where essentially your agency ran out of kits to distribute?
A. No.

Q. Moving again up, backwards from the list you gave me, education is another service, substance abuse service provided by your agency that you told me about. What generally are those services?

A. You are referring to the alcohol other drug?

Q. Any substance abuse, and I don't need to know the specifics, and I'll follow up if I do, but generally, could you give me an overview of the type of education provided by your agency on substance abuse?

A. We provide any number of program areas in relationship to identification, how do we help families be successful in the treatment of addiction, a chronic disease. We help families and individuals come to terms with the fact that this is a chronic disease and that it will need a lifetime of interventions.

We work with individuals on how to be successful in the employment, how to get information to them about training programs. Many of the individuals that we serve have been entangled with the criminal justice system, so they often have some things they have to

straighten out in order to be successful in treatment, but, for the most part, a lot of our education focuses on understanding the need for long-term solutions to addiction.

Q. Now, the education services you described, is that something that Summit County Public Health has been doing for more than ten years?

A. We haven't, as we didn't have that program until we merged. So we have only been doing it since we merged, which would have been 11. So we have been doing seven years.

Q. All right. So let me follow up and try to understand how your agency has changed since the merger. And essentially, what you are talking about, you mentioned Barberton in 2010, but it sounds as if you are really focusing more on the 2011 merger with Akron's health department?

A. That was the largest. Barberton had a small number of employees that were easy to integrate. It was a community of about 20,000 people. So it wasn't as difficult to bring them to join with us, and we had had Barberton prior, we have done a lot of work in

that area, but Akron had -- was much larger, had many buildings we had to assume, fleet cars, there were a lot -- and there were some programs that we didn't do and we had to assume. So it was a much more difficult merger.

Q. So prior to 2011, based on what you had said about education programs, it sounds like Summit County Public Health wasn't doing substance abuse education programs?

A. No, we were not. No.

Q. No.

A. Excuse me.

Q. Why was that? Was it a coordinated division of labor --

A. Yes.

Q. -- between local agencies?

A. Yes.

Q. And Akron was responsible for the substance abuse education?

A. Yes.

Q. What dictated the merger of these health districts in 2010 and 2011?

A. At the state level, there is a push for health districts to merge, to some extent,

to save resources.

The other issue locally was the City of Akron was at a point where they had lost their health director. Their city charter needed a board certified prevention specialist physician to take that role on, and that was difficult, to find that person to assume the role as a health director.

Also they had -- they were looking, the mayor, at that time, was Mayor Plusquellic, and he was looking for cost savings, and he was looking for efficiencies. So as it was being -- and accreditation was just on the horizon for local public health entities to become credentialed and accredited, so he felt it was a good time to bring it forward. It had been talked about in previous years, but never had the political will.

Q. Was Akron -- and I'm talking about from an administrative perspective, employees, services, revenue, expenses, was it actually a bigger health district than Summit County Public Health --

A. No.

Q. -- agency?

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A. No.
Q. If you recall, prior to the merger, do you know what Summit County Public Health's, essentially, budget was prior to the merger?
A. I want to say it had to be somewhere between 12 and 15.
Q. And to the best of your recollection, what would Akron's revenue/budget have been around that time?
A. I think it was 6.3 million. But remember, it's a city department, so that was their departmental budget.
Q. What is the combined, and I actually, I guess, I better ask this to be complete. At the time of the merger with Barberton, which you said was a much smaller health district --
A. Yes.
Q. -- what was their budget prior to merging into Summit County Public Health?
A. About a million.
Q. And as we sit here, and I don't know whether we are in a 2018 budget or 2019 budget.
A. 18.

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Q. Okay. What is Summit County Public Health's current budget for the 2018 fiscal year?
A. About 24 and a half million.
Q. Has that number been in the same general neighborhood since the 2011 merger?
A. No.
Q. How has it changed since 2011?
A. It's increased.
Q. So if we use -- can we use 2012 as maybe the first full budget year that included Akron and Barberton together?
A. No, because that would be wrong. In that -- the first, when we merged, we, in the contract with the city, had agreed to do a three-year trial period of budget expenses, where we would keep, actually, each two set of books and keep them absolutely separate. So we would know exactly what it cost to administer that health district, that city department.
We felt as though that at 6.2, it was way too high, that it shouldn't cost 6.2 million to do that, but we weren't sure.
So we did three years of a trial, a trial, sort of, budget period. When it came

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time to then actually formalize a contract that renews each year for us to be the health department, it actually became -- we were able to get the cost down to about 3 million, about 3.3 million, and that's actually what the -- actually what the contract is for now. So after that, so probably the first budget year that would be reliable would be 16.
Q. And so in 2016, incorporating those cost savings --
A. 15 might be too. I'm sorry.
Q. Maybe 2015, you said?
A. Yes.
Q. All right. I'm just trying to get a big picture from you --
A. Yes.
Q. -- I don't need to the dollar and cent exact. But in 2015, what was the budget for Summit County Public Health?
A. I want to say it was probably about 21 million, 20, 21 million.
Q. And that includes all sources of revenue?
A. Yes.
Q. Outside funding, State of Ohio, for

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example?
A. Yes.
Q. Plus general revenue from levy revenue?
A. We don't have levy. We have inside millage from property taxes.
Q. 2016, if you recall, how did what change?
A. That's probably up by a million, probably.
Q. About 22 million?
A. Yeah.
Q. 17?
A. Probably up a lit bit, 23, 24, somewhere in there.
Q. And then you said it's about 24 and a half this year?
A. Uh-huh. Yes.
Q. Has Summit County Public Health started its 2019 budget process?
A. Yes.
Q. Can you give me a general description of how the budget process works for your agency, within the context of the overall Summit County government budgetary process?

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A. Okay. In revised code, we are a separate taxing district, therefore, we do our own budget. So we will look at -- each division head will look at the needs and the cost.

We pretty much know what our revenues are going to be, except with some fluctuations, maybe some permitting fees or how much we are actually going to bring in, but we know what the City of Akron contract says, we know what the inside millage is, we know roughly what we receive in permits and contracts that we are required by law to charge, like for birth certificates and well permits and sewage permits, and then the remaining amount of our dollars, the other 12 and a half, is soft grant money that we find in order to provide additional services for individuals.

So when that budgeting process starts, we know what we are required by law to provide services, and then each division director looks for additional dollars to provide services to the community, based on the community health improvement plan.

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Q. Does Summit County Public Health have one community health improvement plan --

A. Yes.

Q. -- or goes each division have one?

A. Each division contributes to that, plus the community at large. We are responsible for the offering of one document.

Q. Is that an annual document or is it --

A. It's now, based on the state, it's an every-three-year document.

Q. Which -- what's the current version in effect, what years does it cover?

A. We are in 16, 17, 18. It will be redone in 19.

Q. So with respect to the budget, you mentioned there is the permits and contracts, the fees that come in?

A. Correct.

Q. Are those earmarked, do they have to be spent on specific purposes, or are they general revenue to your --

A. Well, we have to -- let's take vital statistics, for example. We charge $22 per birth certificate. We have to. We keep

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$3. The rest is remitted to the state. So the $3 we keep is earmarked for vital statistics, to keep that operational.

Most of our dollars -- we don't make money on anything. So we're poor.

Q. Property taxes, does that go into a general revenue fund?

A. Yes.

Q. So that would pay for salaries, benefits, for example?

A. Correct.

Q. Does it also pay for services, substance abuse services provided to clients or patients of Summit County Public Health?

A. A little bit.

Q. The grant money, do those pay for salaries and benefits?

A. Sometimes, yes.

Q. Is that the primary source of revenue for, for example, substance abuse services provided to agency clients or patients?

A. Yes.

Q. Currently, I think you said, it's 12 and a half million, give or take?

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A. That's grant money.

Q. Of grant money, yeah.

How has that number changed since 2015?

A. It increased. It increased.

Q. So roughly what was it in 2015?

A. I want to say it had to be around maybe 9 or 10 million.

Q. Of the current amount of 12 and a half million, do you know how much of that, roughly, goes towards providing the substance abuse services we were talking about earlier? You can do it by dollar amounts or by percentage.

A. Some of our grants are multiple year grants. So like we have a 1.5 SAMHSA grant to provide education and outreach, risk behavior, as far as looking at training and any number of things.

That grant runs over five years, so if I look at per year, we get about 300 a year on that grant, we get another, I would say, probably close to a million -- well, our contract -- maybe a million and a half.

Q. Goes towards substance abuse

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programs?
A. Yeah, a million and a half. I would say a million and a half to probably 1.75.
Q. And does your agency track -- I'm sure it tracks -- strike that. Let me start all over.
Does your agency track how much of that 1 and a half to 1.75 million is actually used for opioid-related services?
A. Only in those programs that are specific, like Narcan, naloxone or -- yeah, that would be it probably, those that are specific, MAT.
Q. So other than going grant by grant and knowing what the purpose of the grant is, there isn't any sort of other accounting being done in your department to carve out this is going toward opioids, this is going to meth, this is going to go to --
A. It could be. This is probably a lot more information, but the State of Ohio started something call deliverable-based grant reimbursements. So if your grant is for $300,00, completing OARRS training and

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education with physicians, if you did 50 physicians, that maybe bring in $50,000.
So if it's a deliverable-based grant, we would know the specific objective that had to be met in order to receive that money, and we would know if it was grant or not, if it was opioid related.
Q. But again, that would require us to go on a grant-by-grant basis --
A. Correct.
Q. -- and know what the grant is for and do that math, but if it's just a top-line budget or revenue analysis, there isn't a category that says opioid-related expenses?
MS. KEARSE: Object to form. You can answer. I just objected to the form of the question.
A. No.
Q. And then, so just to tie that off, as we sit here today, if I started in 2015 and worked up to 2018, could you give me a number or a percentage of that substance abuse expenditure that is related solely to opioid-related programs?
A. 50 percent.

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Q. And is there somebody, if you had to go and pinpoint that number to the best of your agency's abilities, is there somebody within your agency you would go to ask for that analysis?
A. Yes.
Q. Who is that?
A. Jackie Pollard.
Q. By the way, I had asked how long she had been assistant director of AOD services. I did not ask how long she has been employed by Summit County Public Health. Do you know?
A. The same. She has been there about a year.
Q. So she was new to the agency --
A. Correct.
Q. -- when she took the current position?
A. Correct.
Q. All right. There were two more service categories that we haven't talked about yet that you gave me earlier in the deposition. We have been talking about education. The next one on the list was counseling.

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A. Yes.
Q. Can you give me -- well, first of all, is Jackie Pollard responsible, kind of the supervisor of that program as well?
A. We actually have an additional supervisor in there.
Q. Who is the supervisor for counseling service?
A. Griffin Brown. It's G-R-I-F-F-I-N, Griffin Brown.
Q. And that's a Mr. Brown?
A. Yes.
Q. How long has he been that assistant director?
A. He's a supervisor.
Q. I'm sorry. A supervisor.
A. Probably four months. We just hired him.
Q. Was he hired into a new position or was he hired to replace somebody?
A. He was hired in to replace somebody who had left.
Q. And who was that previous person?
A. It would have been Victoria. Yeah. Her name is Victoria.

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Q. Is she like Cher, one name, Victoria?
A. Yeah. Victoria. I'm trying to think, Victoria. I don't remember her last name though.
Q. How long was she in that position?
A. Probably a couple years.
Q. And do you recall who would have had that position before her?
A. Yvette Edwards.
Q. What is the -- what is the role of a counseling supervisor?
A. They oversee practice standards and make sure that the counselors are meeting their productivity standards, and that they are actually providing quality counselling and review, and do supervision with each of them, and try to make sure that the service delivery is on par with best practice standards in what they are doing.
Q. How many counselors does, and we are just talking about substance abuse, although if you can't answer that, then we can dive into it deeper, but how many counselors are there at Summit County Public Health that

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provide substance abuse counseling?
A. I believe there are eight.
Q. Has that number been roughly the same since you have been the health commissioner?
A. Yes. Seven, eight, somewhere in there.
Q. And within that group of counselors, are there some that have -- are they generalists or are they specialists, if you know?
A. Most of them are LPC, licensed personal counselors, and they all have substance abuse certifications. Some are LISWs, licensed social workers, some of them have independent status.
Q. What does that mean, "independent status"?
A. It's like you actually become a social worker, and then you become an LISW, which is independent, and then you complete a two-year supervision period, and you are allowed to supervise other social workers.
Q. Okay. So of the seven to eight that -- counselors that have been with Summit

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County Public Health in the last few years, has there -- strike that.
Are there some counselors that deal with certain substances, or do they just see whoever comes?
A. Yes. No, they do an assessment that points them towards what the problems might be, what the addictions, and they handle it.
Q. All right. So if you have a client who comes in and they are dealing with opioid addiction, is there one or more specific counselors they are directed to, or could any of them actually take that case?
A. Any of them can do that.
Q. Who is the longest tenured counselor in the group currently employed by Summit County Public Health?
A. Myron Lewis, I believe.
Q. How long, to your knowledge, has he been a counselor for your agency?
A. Again, we merged in 11, so he has only been with us seven years. Prior to that, he was with Akron.
Q. How many of those seven or eight

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have been with the agency since that merger seven years ago?
A. I'm going to say two to three.
Q. Who were the other one or two, other than Myron?
A. Victoria and Deonna, but I'm not 100 percent sure Deonna came with the merger.
Q. What is Deonna's last name?
A. I don't know.
Q. And so Victoria, when we were talking about counseling supervisors, you couldn't remember her last name, she is still with the agency, but is no longer a supervisor, is that --
A. Correct.
Q. If you had a question about opioid addiction, who would be the person you would speak to, whether it's a counselor or a supervisor or an assistant director, anybody within Summit County Public Health, who is the person you would go ask that question to?
A. Jackie Pollard.
Q. What is her background, if you could give me a --
A. She is a social worker, spent a lot

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of years in Stark County Mental Health, alcohol, drug other counseling, she worked for the ADM board down there for many, many years. She has a history, a long history of counseling services. She is very well versed.

Q. Of the three counselors that, to the best of your recollection, have been with your agency for about -- since the merger roughly --

A. Yes.

Q. -- which of those would you speak to if you wanted to know something about opioid addiction in Summit County?

A. Probably Myron.

Q. With respect to the counseling services that these folks are providing to Summit County residents, how many, roughly, clients or patients does the agency see in a given year, substance abuse?

A. I think it's about 800 to a thousand.

Q. And are those walk-in-type services, or are they regularly scheduled, or does it vary?

A. It varies.

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Q. Can someone just walk into the clinic?

A. Yes.

Q. And they are seen the same day?

A. Yes, if they choose to be.

Q. With respect to the 800 to 1,000 clients that are provided substance abuse services, has that number been roughly the same since you have been health commissioner, if not, how that has it changed?

A. It's increased.

Q. From roughly what, to the 800 to a thousand?

A. Around 500, 600.

Q. And that's in 2015?

A. 15, 16, yes.

Q. What has driven the change from 500, 600 to 800 to a thousand?

A. Quite honestly, a lot of our clients come via court referral. So when somebody finds themselves in trouble, and as part of their probation or part of that, they end up seeking counseling through us. And because we have seen such an increase in the use, all the agencies in town have seen an

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increase in the numbers.

Q. Okay. And you said, "An increase in the use." Do you mean the use of substance --

A. Substance abuse --

Q. -- illegal substances generally?

A. I'm sorry.

Q. Do you mean generally all substances or do --

A. All substances.

Q. One, and we will, I'm sure, talk about it a little bit later, one substance would, of course, be heroin?

A. Yes.

Q. Fentanyl, perhaps?

A. Yes.

Q. I'm going to, throughout the course of the day, and if we need to clarify as we go, I'm happy to do it, but when I refer to illicit opioids, would you understand that to include heroin and fentanyl?

MS. KEARSE: Objection.

A. Yes.

Q. And then there are, of course, prescription opioids?

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A. Correct.

Q. Which can be used illegally too, if they are, for example, stolen from a family member; would you agree?

MS. KEARSE: Object to form.

A. Yes.

Q. But they are legal -- legally approved FDA products; is that your understanding?

A. Yes.

Q. How many of the 800 to a thousand patients, roughly, if you know, are seeking counseling services based on use of illicit opioids?

A. I don't know that.

Q. If you know, how many, in number or percentage, of that 800 to a thousand are seeking counseling services for opioids versus any other substance?

A. I couldn't answer that. That's personal health information that's contained in the assessment.

Q. Okay. And the assessment is something that is done by the counselor when he meets with -- he or she meets with the patient?

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A. Correct.
Q. Are those records that are maintained by Summit County Public Health?
A. Yes.
Q. And where would those be maintained?
A. 1867 West Market.
Q. And each client has a personal file, sort of like a medical record?
A. Yes.
Q. How long are those medical records required to be maintained pursuant to that retention policy?
A. I am not sure.
Q. Would we talk to Mr. Nemecek --
A. Yes.
Q. -- or Ms. Pierce about that?
A. Either.
Q. Either. And are those maintained -- does Summit County Public Health have an electronic medical record system, or are those hard copies?
A. Hard copies.
Q. I had asked you, you know, roughly, if you knew, and you didn't, to be fair, what

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the general breakdown was of the 800 to a thousand patients regarding what substance that they were abusing.
If we were to go back in time to that 2015, 16 time frame when that is 5 to 600, would you be able to answer those questions?
A. No.
Q. I have seen documents that, and I probably have one, and we can talk about it later, but it describes various -- well, it describes opioids being the number 2 reason why patients come in for counseling services for men. I don't know if you have seen anything like that, in your work at Summit County Public Health?
A. I'm sorry. I didn't hear that last word you said, for met?
Q. Yeah. For men, men, versus women.
A. Oh, for men. I'm sorry. I thought you said for met.
Q. Yeah. Sorry. It's the number two cause for men coming in seeking substance abuse counseling. Do you know what the number one substance is that they are coming in?
MS. KEARSE: Object to form.

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A. No, I don't.
Q. Is it alcohol perhaps --
A. It could be.
Q. -- does that refresh your recollection?
A. It could be.
Q. In any event though, you would want to ask one of your counselors, or maybe one of your assistant directors, if we were going to break down the number of clients and what specific substances were the most abused?
A. Yes. For accuracy, I would.
Q. The counseling, just to tie off, to tie off these last two categories, the counseling, substance abuse counseling, the revenue or -- how much of the expenditures for substance abuse counseling services come from your agency's budget versus other sources?
A. A small percentage.
Q. Somewhere in that 10 to 20 percent range maybe --
A. Probably.
Q. -- that we used --
A. Probably.
Q. -- for other categories?

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A. Yes.
Q. And the other -- the remainder, whatever it is, would be outside sources?
A. Correct.
Q. And then outpatient treatment would --
A. Intensive outpatient.
Q. Intensive outpatient treatment?
A. IOP.
Q. I don't know what that means, could you --
A. Those are programs that are set up, when it is determined that someone doesn't have to go to a facility or be inpatient, that they can be in an intensive outpatient program, which means they show up every day for a required number of hours, they run through any number of activities, and then they get to go home.
Q. Are there individualized treatment plans?
A. Yes.
Q. So one person might be in there for six months, one person might be 12 months?
A. Correct.

Q. How many -- did you say IOP or IOT?
A. IOP, P as in Paul.
Q. Okay. How many clients or patients does your agency provide IOP treatment to?
A. I am not sure.
Q. Is it in the dozens or is it in the hundreds?
A. It would be hundreds.
Q. And the expenses associated with that program, what percentage is from your agency's budget versus outside sources?
A. Maybe 10 percent.
Q. The intensive outpatient treatment, does it perhaps also incorporates the medication-assisted treatment, or are those completely separate programs?
A. They are separate.
Q. So is this counseling just on another level than --
A. Yes.
Q. And with respect to the assistant director, Jackie Pollard, and some of the counselors we talked about briefly over the last 20, 30 minutes, are they the same people who are administering this program?

A. Yes.
Q. And if I were to ask the breakdown of patients and whether they are using opioids or some other substance, would you know that data?
A. I would not.
Q. And same question with respect to the maintenance of patient records, would your answers be the same as to where they are stored and what is stored and it's hard copy versus electronic?
A. For intensive outpatient?
Q. Yeah.
A. It's the same, yes. I know where they are at, yes.
Q. And what was the -- what did you call the initial assessment form that's done, did you just say it is an assessment?
A. An assessment, an AOD assessment.
Q. Is that an actual preprinted form?
A. Oh, yes. It's a tool.
Q. And so that's done with the counseling patients and that's done with the IOP clients or patients?
A. Yes, on intake.

Q. And does Dr. Sobolewski oversee either one of these last two programs we have been talking about, the IOP or the counseling services?
A. No.
Q. How about the ADM board, anybody from the ADM board of Summit County, whether it is Dr. Smith or Mr. Craig, that assist your department in providing those counseling or IOP services?
A. Yes.
Q. How does that work, what is the interaction there?
A. Alcohol, drug, mental health boards in Ohio are not allowed to provide direct services. Therefore, they contract with everybody for services that they want to see happen. They contract with us.
They are responsible for indigent care, so out of those 800 to 1,000 individuals, some of those patients we will seek reimbursement, either through private insurance or Medicaid, but then there is another group that are deemed indigent.
The ADM board, alcohol, drug and

mental health, will then reimburse us for those individuals that we see. And they do that with about -- I think they have about 30 subcontractors around town.
Q. Is Summit County Public Health the only political subdivision or government entity to which they have that contract? And that's a terrible question. Can I ask it a different way --
A. Yes.
Q. -- if you don't you mind?
A. Yes, please.
Q. Are the other -- other than Summit County Public Health, are the other entities with which ADM contracts private entities?
A. Some are, some aren't. I would say like the jail, Summit County jail, Oriana House, those are quasi political. Perhaps they may do some work with -- they do work with different groups. So I couldn't say for sure they were all not for profit or private.
Q. With respect to how ADM reimburses your agency, is it a per-patient reimbursement or is it a -- do they just give you a certain budget per year to provide services?

A. Our contract is for $700,00, about 6 to $700,00. And so we are allowed to spend up to that much, but we see as many people as we can. So we try to seek as much outside reimbursement so we don't have to use those dollars.

Q. And just so we are clear, to tie this off, this 6 to 700,000 per year is to provide substance abuse services to indigent residents of Summit County?

A. And/or those with -- you can have insurance, you can have private insurance. You don't have to necessarily be indigent. There is just a pay or mechanism if you are indigent.

Q. Okay. Gotcha.

MR. NAEEM: Anne, do you want to take a few minute break?

MS. KEARSE: We have been going -- how long have we he been going? We can take a break.

THE VIDEOGRAPHER: Almost an hour and a half.

MS. KEARSE: Ten minutes?

MR. NAEEM: Yeah.

THE VIDEOGRAPHER: Off the record

at 10:32.

(Recess taken.)

THE VIDEOGRAPHER: On the record, 10:51.

MR. NAEEM: Before we continue with the deposition, would the folks on the phone go ahead and identify themselves for the record.

MR. MILLER: Hello. Yes. Hayden Miller, of Ropes & Gray, for defendant Mallinckrodt LLC.

MR. FRANCO: Joe Franco, with Holland & Knight, on behalf of Insys Therapeutics, Inc.

MS. D'ANNA: Samantha D'Anna, from Jackson Kelly, on behalf of Miami Luken.

MR. BROWN: Elliott Brown, from Morgan Lewis, on behalf of Teva.

MS. GATES: And here in person --

MR. RUIZ: Anthony Ruiz, from Zuckerman Spaeder, on behalf of CVS Rx Services, Inc. and CVS Indiana, LLC.

MR. NAEEM: Anybody else on the phone?

MR. RAIOLA: Yes. Stephen Raiola, with Covington Burling, on behalf of McKesson.

MS. GATES: In person, Lisa Gates, Jones Day, for Walmart.

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(Thereupon, Deposition Exhibit 1, Organizational Chart, Dated January 2017, Bates Labeled Summit 155008, was marked for purposes of identification.)

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(Thereupon, Deposition Exhibit 2, Organizational Chart, Bates Labeled Summit 180563, was marked for purposes of identification.)

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BY MR. NAEEM:

Q. Ms. Skoda, I have had marked as Exhibit 1 and 2 a couple org charts we found in your custodial documents, and I don't want to spend a lot of time on these, but we have been talking about the services provided by Summit County Public Health, substance abuse services, and some of the folks who provide those services.

If we look at Exhibit 1, is that

representative of the current organizational structure of Summit County Public Health?

A. Yes.

Q. And underneath Citizens of Summit County, there is a district advisory counsel, and below that Summit County Board of Health, and below that is health commissioner, which is you, correct?

A. Correct.

Q. Medical director off, as we are looking at, it to the left, would be Ms. Sobolewski?

A. Sobolewski.

Q. Sobolewski, I apologize, who's been around since roughly the beginning of the year, in that position?

A. November-December of 17.

Q. And Margo Erme -- no. Yes, Margo Erme, Dr Margo Erme prior.

Did she come over with the merger?

A. Yes.

Q. So she was with Akron?

A. Correct.

Q. And she took the medical director position at Summit County Public Health --

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A. Correct.
Q. -- in 2011. Did Summit have its own medical director at the time, or was that person laid off?
A. Yes. We had a four-hour a week medical director, and when we merged, Margo came over with the merger. He had a full-time -- he worked elsewhere full time as an occupational health physician, and he went to work for Akron General Medical Center.
Q. And his name?
A. Ronald Hawes, H-A-W-E-S.
Q. And so at that point in time, at the time of the merger, you said it was roughly four hours a week?
A. Correct.
Q. Okay. All right. And then if we go back to Exhibit 1, there are two deputy health commissioners and an assistant health commission year; do you see that?
A. Correct.
Q. Okay. Jackie Pollard is the person who is the assistant health commissioner?
A. No. Jackie is an assistant director under community health, which would be

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the second box from the left.
Q. Let's fill in this with a few names then.
A. Okay.
Q. I'm not going to do the whole thing, and we will compare it perhaps maybe to Exhibit 2 in a second, but first of all, who is the assistant health commissioner?
A. Tonya Block.
Q. How long has she been employed by Summit County Public Health?
A. Maybe 13 years, approximately.
Q. And if we are looking at Exhibit 1, there is a direct line between the assistant health commissioner and the director of these various departments?
A. Correct.
Q. There is no direct line from the deputy health commissioner to those departments?
A. Correct.
Q. Is that because they have administrative functions?
A. Yes.
Q. What are, generally, the two -- and

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there are still two?
A. Yes.
Q. All right. What are their responsibilities?
A. They vary from any number of special projects that they work on. They look at basically -- we give direction and provide services, they look at any number of programs within the health district, and they look for improvements, but they are all from an administrative perspective.
So they have a list of projects that they work on. Some may be from building facilities to launching new software programs to monitor our strategic plans, to look at outcomes. They work on any number of special projects.
Q. But neither of those two people would have oversight responsibility for substance abuse programs provided by Summit County Public Health?
A. No. The only piece that one of the deputy health commissioners, Heather Pierce, would have, she has assisted with behavioral redesign in Ohio. You may have heard, in July

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of 17, they flipped the switch, and now we are under behavioral redesign, where they are changing the payment and reimbursement structure. So she has helped with that, at an administrative level.
Q. At an administrative level for the repayment of services provided?
A. Correct.
Q. But not actually the termination of the programs themselves?
A. No. The state did that.
Q. And the behavioral redesign, that applies to substance abuse or the --
A. The entire State of Ohio. All mental health, all alcohol, drug mental health services.
Q. And that's essentially how the State of Ohio reimburses local health district for those services?
A. And ADM boards and everybody.
Q. And then if we go back to assistant health commissioner, there is currently, as of January 2007, {sic} when this chart is dated, five director positions for various departments.

Do any of the five, other than community health, provide substance abuse services to citizens of Summit County?

A. Not direct care, but other than -- the MAT program is a blending between clinical services and the community health folks, for the training and the counseling that goes with it.

Q. Okay.

A. Within clinical services, the STD, HIV communicable disease unit, there is a lot of education regarding substance use disorders.

And then the personal responsibility education program is a 13-county project that reduces risk behaviors in youth. So they do some education around substance use disorders.

Q. Who then is the director of clinical services?

A. Leanne Beavers.

Q. And how long has she been with Summit County Public Health?

A. Since December -- excuse me, October, whenever they came over in 10. It was the end of 10. So I want to say it was like

October of 10. Barberton Health Department joined Summit County.

Q. So she was previously with Barberton --

A. Yes.

Q. -- at the time of that merger. Okay.

So clinical services does provide some services to substance abuse patients or clients along the lines you just described. Is it accurate for me to say though that the bulk of services are provided through the community health division?

A. Yes.

Q. And who is the current director of that?

A. Community health?

Q. Yes.

A. Donna Barrett, B-A-R-R-E-T-T.

Q. And how long has she been in that position?

A. Three years, two to three years.

Q. And how long has she been with Summit County Public Health?

A. Two to three years.

Q. All right. And are there any -- as we were talking before we took a break, we had gone through the list of services, substance abuse services generally provided.

Is there anything on this list that we didn't talk about that you would want to add regarding the services provided to substance abuse patients or clients?

MS. KEARSE: Object to form.

A. No. The only thing that we didn't talk about, that I doubt when I see this, within community health, if you look at the STARS programs, S-T-A-R-S, that again was a federal grant. It was actually a research grant to look at alcohol drug assessment in the home, and that was -- we were in partnership with children's services, Summit County Children Services, and that is in-home assessments, and we did the assessment and provided some of the wraparound social support services.

But that actually was in order to help reduce the number of children that were being taken out of homes because of safety issues with the rise in opioid use.

Q. Okay. And some of the answers you just gave, or some of the testimony you just gave sounded in the past tense. Is that an ongoing program?

A. Well, it was -- it's been -- it was a five-year research grant, so it's over now. We are continuing the program, but it's without that money.

Q. And --

A. And it ends September of 18. The grant is just ending.

Q. Okay. After September of 2018, who will provide funding for those programs?

A. Summit County Public Health will provide part of it. ADM board may be able to provide some of it with peer recovery coaches for families. They certainly would be able to pay for the in-home assessment under our current contract that we have.

But it will just depend on how many people we get and how it -- in the final shakeout, as to what it looks like as it goes forward.

We have committed about 65,000 of general revenue dollars to make sure that this

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group of individuals can continue to have social support in place.
Q. So that's $65,000 for the year?
A. Yes, starting in September.
Q. But not through the end of this year --
A. Correct.
Q. -- that would be for the 12-month cycle?
A. 12-month cycle.
Q. Does children's services provide any revenue for this program after September of 2018?
A. I am not sure what they have decided to do with that piece.
Q. Okay.
A. I know we have made a commitment.
Q. And we talked about the counselors that provide substance abuse services to patients or clients of public health. Are those the same people that do the in-home assessments?
A. Yes. It is usually just one of them though.
Q. One has responsibility for this

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program?
A. Yes.
Q. Who or which of those counselors is responsible for that?
A. Victoria.
Q. Okay. If we look at Exhibit 2.
A. Okay.
Q. This looks to be, in my review, an org chart of just the community health division of Summit County Public Health.
It's dated obviously, correct, it's not current?
A. Oh, yes. That's what I was going to say, it is dated, and it's when -- it happened during the time when we were separating clinical services into a very specific unit, and we removed the two darker colored, gray-shaded boxes, we removed those individuals, and actually that became part of population health.
So we created a new division of epidemiologist, assessors, those sorts of things, and they became on their own in population health.
So then Leanne, at the time, was

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the assistant director before she became the director. The director would have been Jill Solem, Jillian Solem, S-O-L-E-M.
Q. Of clinical services?
A. Correct. So this is probably from 15 early -- this is early 15 maybe.
Q. Just a couple follow-ups. So other than the movement of two of these gray-shaded boxes to other divisions, is the breakdown generally the same, even if the people have moved around?
A. No. It is different. WIC and all of its clinical supervisors, the longest box on the left under -- that now went to population health as well, because of the need for the extraordinary data collection on all of our WIC clients. We have about 10,000 moms and babies in that program.
And then HIV, STD, DIS, disease investigation component, went under clinical services as well, but that happened after this rendition was published.
Q. If we look at the box for -- well, at the top it says counseling supervisor, Yvette Edwards?

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A. Right.
Q. And below that are the counselors, and there is seven there currently?
A. Right.
Q. I see Victoria Kaplan, is that --
A. That was her name, yeah, Kaplan. Sorry. I couldn't think of it. And Deonna Green.
Q. Okay.
A. It was Diane Smith. She's no longer there.
Q. Did we talk about the prevention specialist position?
A. Therese Kline?
Q. Yeah.
A. No. I forgot her.
Q. What are their role?
A. They provide prevention special -- in schools.
Q. So they are part of that education --
A. Yes.
Q. -- function?
A. Yes.
Q. And Michael Skoda, is that a --

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A. No. We have a nepotism policy. He was not related.
Q. Is he still with --
A. No. He left after about six weeks.
Q. So if we go through this list of counselors, which ones would I cross off as former employees?
A. Julie Curtis went back to school, Deonna Green is still with us, Myron is still with us, Diane finished her Ph.D., Todd is not with us, nor is a Michael.
Q. And when you say Diane finished her Ph.D., that mean she is no longer with you as well --
A. No.
Q. -- or she is and --
A. No. She finished and she went on to teach.
Q. So the three that I have left are Victoria, Deonna and Myron?
A. Correct.
Q. Okay. Good. We have talked about a lot of things, thank you, so far.
What we didn't talk about was your background. So I want to get some information

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from you.
A. Okay.
Q. I have -- the information I have is that you have a master's degree and you are a registered and licensed dietician; is that correct?
A. Correct.
Q. Would you give me the brief version of where and how you got those various degrees and certifications?
A. You mean all of my college?
Q. Sure.
A. Okay. First I went to school, I was at Kent State University. I finished an undergraduate degree in social work and corrections, and then went on to work for six years as a State of Ohio parole officer, went back to school, took classes at night at the University of Akron to finish my requirements to get another degree in dietetics, to be able to get a master's in nutrition and public health at Case Western Reserve.
Q. I read somewhere that prior to coming over to Summit County Public Health, you actually worked in Cuyahoga County?

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A. Correct.
Q. At the board of health?
A. Yes.
Q. All right. And what was your -- what was your position at the board of health? What did you do?
A. When I first went there, I was employed as the early intervention dietician, provided services, home-based services to children with special healthcare needs and children at risk, and did that for a while.
And then I was promoted to a program manager, and then I started writing grants in all sorts of areas, lead prevention, teenage pregnancy prevention, and I ultimately was a supervisor. Finding money was my job.
Q. Okay. The early intervention dietician position at Cuyahoga County Board of Health, what years did you have that position, if you recall?
A. Oh, yeah. It would have to have been -- it was right when I went there, so it had to be 95, 96, somewhere in there, when I left Metro.
Q. And when did you get promoted to

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program manager?
A. A couple years after.
Q. And how long were you at the board of health; what year did you leave?
A. When I went to Akron -- Summit County, so it would have been like 2000, 2001.
Q. And so when you took the position in Summit County Public Health, what was your initial role?
A. I was told that I was going to come and we were going to develop a community health division, much like we did in Cuyahoga County. It was determined that we needed to -- the health commissioner that was in Summit, I used to work for him in Cuyahoga County. He accepted the position in Summit County and asked me to come work with him there. I had lived in Summit County, so I went there to work.
Q. And who was that commissioner?
A. Gene Nixon, N-I-X-O-N.
Q. So at the time you came over in roughly 2001, the commissioner for Summit County Public Health was Gene Nixon?
A. Yes.

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Q. And how long was he commissioner?
A. 15 years.
Q. I guess I should have asked a different question. When did he retire as commissioner? You took over for him immediately?
A. 2015.
Q. So he had come from Cuyahoga to Summit shortly before you did?
A. Correct.
Q. So you said you were told that you were going to be developing a community health division?
A. Right.
Q. And that was to be your first position when you came over?
A. Correct.
Q. What was your title, if you recall?
A. I think I came in as planning for chronic disease prevention, it was something like that, or policy planning. I can't really remember what I first came as, because I got there and ended up doing a lot of the same functions that I did in Cuyahoga County, regarding grant management, chronic disease

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prevalence, heart disease, hypertension, obesity, physical inactivity.
We had a lot of those grants at the time, and I ended up having to help manage some of those grants and find additional dollars.
Q. And that general function you described, and whatever the title was at the time, how long did you have that position, until what year?
A. Probably three, four years, maybe five.
Q. And were you responsible for securing grants related to substance abuse issues?
A. No.
Q. So after four or five years, you take -- you get a new position or new responsibilities at Summit County Public Health?
A. It was director of planning and policy. Then I became a director. I can't remember what that first title was, but then I became director of planning and policy -- or policy and plans, which was really more administrative operations.

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Q. And what does that mean?
A. Really, it was more just the organization of the units, trying to determine the structure.
We were in the process of trying to figure out really where public health was heading, what sort of new initiatives we should be looking into, what the state was telling us was important in public health. So we were looking at a lot of local -- at the time, the community health assessment, as well as the community health improvement plan weren't as prevalent in public health. It wasn't until later.
We, though, locally, under the direction of county executive Mr. McCarthy, James McCarthy, in 2003 launched what was known as the quality of life initiative, and I was responsible for maintaining that quality of life initiative, which really looked at the quality of life in Summit County, based on a core set of indicators, or 20 indicators that we tracked over time.
Q. Okay. I'm sorry. What year was that initiative?

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A. 2003 it started.
Q. And that was your responsibility --
A. Yes.
Q. -- as director of planning and policy?
A. Yes.
Q. How long did you hold the position of director of planning and policy?
A. Until -- we had merged, and it was after the merger. It must have been 2013 and maybe 14, I became one of the assistant health commissioners.
Q. Okay. And what were your responsibilities in that position?
A. Title change, but not really responsibility change. Had a lot more of the -- still had the -- I was still finding money and looking at the operations in managing the quality of life project.
At that point though, we were starting down the road of accreditation. Health departments had to become accredited, so we were into accreditation, we were doing all sorts of things with the accreditation. So I was really kind of doing a hodgepodge of

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responsibilities.
Q. As director of planning and policy, prior to 2013, did you have any exposure to or involvement with the substance abuse programs that Summit County Public Health was providing?
A. No. We weren't providing them until 11, so maybe those few years, but I didn't have anything to do with them.
Q. Okay. Prior to 2011 then, what were the primary areas that, if not substance abuse, that public health was providing?
A. We were involved with -- you mean, before we merged?
Q. Uh-huh.
A. We were doing chronic disease, life skill behaviors, environmental health, some of the social determinants of health around, you know, socioeconomic housing, education, food insecurities.
We also continually, during that time period, before the Affordable Care Act, another one of the programs I was charged with developing and operating was access to care, which was a donated healthcare program. It's an H-CAP, it's a federal model, and what

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happens in that project is you recruit physicians to donate time.
Once a physician donates their time, they see a client, that we refer them a patient. They then generate a bill, they generate HCFA, they generate -- so you can keep track of what the cost of that donated -- the value of that donated care is.
So we recruited about 500 physicians and specialists to provide care to a group of individuals that weren't eligible for any kind of health coverage.
Q. Okay.
A. We ran that program until Medicaid expansion in Ohio, which is almost four years ago now. We still operate a very small access-to-care program, but don't need to do as much of that now, because people have access to healthcare coverage.
Q. So, and you had mentioned this earlier, and I apologize for forgetting we talked about it, but prior to 2011, Summit County Public Health wasn't providing substance abuse services?
A. No.

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Q. That was being done by Akron?
A. Akron Health Department.
Q. Was Barberton as well providing --
A. No. Barberton was not doing anything either.
Q. Who was the -- well, let me ask a foundation question first. Was Akron's public health department set up similar to the way Summit County Public Health is now?
A. No.
Q. Did they have a health commissioner?
A. Health director, yes.
Q. Health director. Who was the health director at the time of the merger?
A. Well, he was gone but -- he had left, that was one of the issues, but his name was Dr. Moser, M-O-S-E-R.
Q. And you may or may not know the answer, but was he -- prior to him leaving, had he been in that position for a number of years?
A. No. Just a couple.
Q. Do you know who his predecessor might have been?
A. Well, because they have got that

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charter requirement, that you have to have a board certified physician and prevention, they are hard to find. So Dr. Keck left. Dr. Bill Keck was the health commissioner.
They then had a series of administrators who took care -- who kind of worked as just, sort of, interim. They had Mike Smiley, we had -- they had a lot of folks who were just kind of interim in that position, and then they found Dr. Moser, and then he took over.
So I want to say maybe three to four years maybe, and then he retired. I think he still works for NEOMED though, the medical school.
Q. And we are talking about Dr. Moser still?
A. Right.
Q. Dr. Keck, is that K-E-C-K?
A. Yes. Bill Keck, yeah.
Q. Is he still in the area?
A. Bill Keck?
Q. Yes.
A. Oh, yes.
Q. Does he work for any of the local

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institutions?
A. He might still have something at NEOMED. He's in Cuba a lot. He does a lot of Cuban healthcare.
Q. Now, we talked very briefly, early in the deposition, about how your initial exposure to the litigation was being asked to try to find Akron -- records from this prior organization, Akron's health department. Do you recall we talked about that?
A. No, they asked costs that we had as the health district, not Akron's. We don't have Akron's stuff.
Q. Well, and that's what I was about to ask. So I will ask it anyway.
A. Oh, no. It was a clean break. When we merged, we said you take you stuff, we take our stuff.
Q. So anything related to substance abuse services provided by Akron is not maintained currently by Summit County Public Health?
A. No, it is not.
Q. Do you know what happened to the records of Akron's health department at the

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time of the merger?
A. Unfortunately, no.
Q. Now, some of the employees -- some of the current public health employees, particularly in the substance abuse arena, seemed to have been prior employees of Akron's health department?
A. Yes.
Q. Do you know, did they bring, for example, client or treatment records with them, when they came, to maintain continuity of care?
A. They may have. I don't know that for sure.
Q. And just to clarify, what I thought I heard from you about the budget information, you were asked to provide financial information regarding Akron's contribution to public health since 2011, or to find pre-2011 records from Akron's --
A. No. They had asked us for any costs we had associated with opioids or opiates for, like, 14, 15, and 16, which would have been our years. That was it.
Q. Okay. But it was Akron making that request of you and your agency?

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MS. KEARSE: I'm just going to raise an objection. I think there was counsel involved in the request. That would be privileged information.
Q. Did Akron's health department have its own board of health, overseeing its department?
A. Yes. In the charter, they have a five-member board that looks at directing and advises the mayor on health issues.
Q. So immediately above you, for example, on Exhibit 1, is a board of health?
A. Correct.
Q. And those are appointed?
A. No.
Q. No.
A. Well, kind of. Not really appointed, in the sense of appointed.
Within the structure of a board of health, it is governed by a district advisory council, meaning that every single city, and then political subdivision, can have a member on our board.
So our board is large. It's 18 members, unlike many health districts

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surrounding the state that are not that large. But we have the 13 cities, we have four at-large members, so that makes 17. They represent the townships and the villages. And then we have one licensing counsel member, because we levy license fees, and they are allowed to weigh in on what the licensing costs are.
So our 18-member board is very different. So when, let's say, the City of Green wants to have a member, the mayor can pick whoever he wants and put on our board.
Q. Okay.
A. Many of our board of health members have served for years.
Q. And so the district advisory counsel are the actual executives of those cities and --
A. Political subdivision, correct.
Q. And so they have the ability to select the member who is going to represent their subdivision on the board of health?
A. Yes. But they usually ask us, "Do you know anybody?"
Q. What is the role of the board of

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health, how do you interact with the board of health?
A. We have a monthly meeting. The board of health is an administrative -- again, they are required to sign off on all the approvals, travel, they approve all of our vouchers, but they are an administrative board.
Q. Do they approve line-item expenses?
A. In the -- they approve the final budgets, but they do not have to approve expenditures at a line-item level.
Q. So hypothetically, if Summit County Public Health contracts with an outside provider for anything, make something up, that would be done externally, does the board of health have to approve that contract before you enter into it?
A. If it is over $25,000.
Q. Otherwise, you have currently --
A. Right.
Q. -- discretion?
A. And we report that to them and tell them what we do.
Q. So you have quarterly meetings with the board of health?

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A. We have monthly.
Q. Monthly, I'm sorry. I actually wrote that down.
And to your knowledge, did Akron's health department have a similar structure, even if the numbers were different?
A. No. They have a five-member board.
Q. And who selected those board members?
A. The mayor.
Q. All right. And is all of this governed by state law?
A. They are charter. It's the city charter, but the DAC boards of health is revised code.
Q. Okay. Gotcha.
A. The board of health still exists within Akron. They didn't change the charter, when they merged.
Q. So there is a currently operating --
A. We haven't met in seven years.
Q. But it still exists on paper?
A. Yes.
Q. Are people getting paid for it?

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A. No. Volunteer. All volunteer.
Q. We were talking a little bit about the transition from Akron's function with the substance abuse to now Summit County Public Health, and there was some names I wanted to ask you about, one of whom came up. Gene Nixon, he was your immediate predecessor?
A. Yes.
Q. I think you said he was there from 2000 to 2015 roughly?
A. Yes.
Q. When you were directing your staff, your colleagues, to compile records for this litigation, do you know whether Mr. Nixon's records were collected?
A. I can't honestly -- I mean, I really don't know, to be quite frank. They did just an archive dump. So I would assume anything in there archived would have come with it.
Q. And "archive dump," what are you --
A. When we had -- all the records are kept electronically. So we just went in and, I think, literally just took it and loaded it to a jump and gave it, because we were told

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everybody else would go through anything. So any open records request we get, we give what they ask for.
Q. And to follow up on what you said, were you responsible for dumping your own electronic documents to a flash drive?
A. No.
Q. So somebody came in and did that?
A. Yes. You don't want me doing that.
Q. Yeah. So with respect to how you operate on a day-to-day basis, interacting by email or memos and things like that, do you store documents on your hard drive?
A. On the computer?
Q. Yes.
A. We're not allowed.
Q. Okay. Where do you store them?
A. They all go to our public drives. HSL shared library, and even my H drive, which is on -- so like my space on the big, old server, it's not mine to control. So when you dump it, I don't -- whatever I have in there is in there.
Q. So you wouldn't be able to go in, for example, and delete something?

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A. No.
Q. And is the process for how those documents are saved automatic, or do you have to move documents over from, for example, your email into one of the H or S or other drives?
A. No. It's automatic?
Q. When you create a document, hypothetically, if you created a document in Microsoft Word, where would that document save to?
A. H, L or S. I do have a bad habit of working on my desktop until I get it done and then sending it, and IT sends me hate mail and takes it over to H.
Q. And your emails, do you manually delete them, or do you put everything into archive folders?
A. Archive. The only thing that we are allowed to delete is like transitional emails. "Do you want to go to lunch?" "How is your mother?" We are not allowed to delete anything with any content.
Q. And do you know what the -- we talked just very briefly about the document retention policy --

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A. It wouldn't matter if you --
THE NOTARY: Wait a minute.
A. I'm sorry. Even if you delete them, they are still saved.
Q. But as a practice, you only delete those transition emails or anything else?
A. Yes.
Q. Do you move those into subject matter archives?
A. No. They are automatically saved.
Q. So if you were to open your computer right now and use your email program, would you see five years' worth of emails?
A. Yeah.
Q. And just to be clear, do you have any subject matter folders in your email system that you save things to?
A. I do sometimes, yes.
Q. Do you have one of those subject matter folders for anything related to substance abuse or opioids?
A. Yes.
Q. How long have you been maintaining that particular folder?
A. Probably a couple years.

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Q. And did you have any responsibility for making sure that that was something that was collected --
A. No.
Q. -- by -- but somebody just took care of the hard drive, the email system, they just did that document dump that you talked about?
A. Yes.
Q. And then, I'm sorry, going back to Mr. Nixon, you don't know whether someone specifically found and collected his, for example, emails or his former hard drive?
MS. KEARSE: Asked and answered, that question, but --
A. No, I don't. If it was in those archives, it got dumped.
Q. I saw another name, Rich --
A. Marountas.
Q. Marountas. All right. He is an epidemiologist?
A. Yes.
Q. And how long has he worked for Summit County Public Health?
A. Oh, probably for about 12 years.

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Q. So he was with Summit County prior to the merger, or did he come over with the merger?
A. He was prior.
Q. Were you responsible for communicating to Summit County Public Health employees the requirements of or the circumstances regarding the production of documents for this litigation?
A. We met, and it's handled like any records request. So when we get a records request and it says dump, or we need all of your sewage files, we don't debate whether we should give them up or not. We just take the sewage files, load them on whatever. Sometimes they give us something, and we have had the case where somebody will say, can you print the sewage documents, and that's millions of pages, and we'll say, that's an reasonable request, we will give them to you electronically.
But typically we just meet, say this is what they want, what's the best way to give it to them, and then we give it up. We probably handle 3,000 record requests a year.
Q. And -- strike that.

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Going back to your background, we talked about your education, we talked about your employment with Summit County Public Health.

Have you had, since you took the position of health commissioner, any further education or training on substance abuse issues?

A. I have attended meetings and trainings, but that would be in continuing education courses.

Q. So you are still required to maintain --

A. Yes.

Q. -- continuing education for your dietician?

A. Correct.

Q. Did you take any of those kind of continuing education courses on substance abuse prior to 2015 when you became health commissioner?

A. No.

Q. So you have done that since?

A. Yes.

Q. And roughly how many programs do

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you think you have taken since 2015 on substance abuse issues?

A. Five or six.

Q. Were any or all of them opioid related?

A. Most were.

Q. Anything else you have done since 2015 to educate yourself on opioids or opioid addiction or substance abuse generally?

A. Yes.

Q. What else?

A. I work closely with Doug Smith, general conversations with individuals in the field, talked to Jackie a lot about, you know, protocols. I have read a tremendous amount about what we can do, as a public health entity, to help keep people alive until they get to treatment and hopefully recover.

So I have done a lot of personal training and education.

Q. Other than conversations, does that personal education involve reading medical literature --

A. Yes.

Q. -- or journal articles?

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A. Oh, yes. It is all refereed journaled articles that are credible.

Q. And when you engage in that process, is it typically because somebody sent you something, or do you go out and try to educate yourself and see --

A. I educate myself.

Q. And to be clear, did you do any of these things prior to 2015 when you became health commissioner?

A. No. The only thing I can say that I was trained on prior to that was more in relationship to addiction in general and the relationship to food and all substances. Because there is, in the dietetics world, there is that food addiction.

Q. So the concept of addiction was something that you understood --

A. Correct.

Q. -- and had been educated on, but not, for example, opioid addiction?

A. Correct.

Q. Conversations with, I'm going to say the word, you didn't say it necessarily, but conversations with experts, reviewing

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journal articles, was there anything else you had done since taking the position of health commissioner to educate yourself on substance abuse issues?

A. We participate with the Ohio Association of Health Commissioners, OAHC. It's the association of Ohio health commissioners.

Also there is the Ohio Public Health Association, Ohio Public Health, and APHA, the American Public Health Association, and NACCHO, National Association of City and County Health Officials. We have worked with them and done -- you know, completed surveys, talked about current trends, used their knowledge and information to help us.

Q. Anything else?

A. I think we were on program areas, what should we be doing from a programmatic area.

Q. So consulting on, kind of, best practices for implementing various programs?

A. Yeah, promising strategies.

Q. Anything else, to close the loop, conversations, reviewing journal articles,

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consulting with various state or other entities, organizations?
A. Probably not. Opiate Task Force, we talked a lot, worked with them.
Q. The Opiate Task Force, my understanding, was formed in early 2014; does that sound right?
MS. KEARSE: Objection.
Q. Have you been involved with that since the beginning?
A. Not as much. My responsibilities were different during 14 and half of 15. So I really wasn't as involved, until I took over as health commissioner.
Q. Okay. Were you generally aware in the early 2014 time frame about the circumstances why it was formed?
A. Yes.
Q. What is your understanding, as to how it was formed?
A. How?
Q. Yeah.
A. The ADM board, ADM, wanted to pursue the development of the Opiate Task Force in Summit County, like many other communities

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had done. So they started to bring together individuals. At the time, it would have been probably Tonya Block and Yvette Edwards, maybe Donna Barrett, I'm not sure. But Jackie wasn't with us yet.
So they brought together some individuals from public health, from the practitioners, providers, and started the talk about how do they develop this, what does it look like.
Within Summit County, there is a few families that have been very active in pushing for the development of an Opiate Task Force. They lost their children, and so they have been very, very active.
And so that helped, sort of, the impetus, and so they brought a bunch of individuals together, decided they were going to start meeting, and I do believe, and I wasn't directly involved until later on, but I do believe they, kind of, hit the ground running with bringing lots of partners to the table.
Q. And just to be clear, when you say "they," you are talking about --

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A. The alcohol, drug, mental health board, yes.
Q. So as far as the driving force for the initiation of the task force, correct me if I'm wrong, it was ADM?
A. Yes.
Q. And were there -- was there a person or persons primarily, to your understanding, involved in pulling everything together from ADM?
A. I believe at the time it was Jerry Craig, and John Ellis was there. He was their director of clinical programs. John Ellis was there at the time. He has since left, and he works at the University of Akron now.
So, yeah, those were the two that I remember.
Q. Was John Ellis still with ADM by the time you became health commissioner, or had he left?
A. I think he probably left pretty -- I can't remember the exact time frame.
Q. And is it your understanding then that when ADM started pulling this task force

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together, they reached out to Summit County Public Health --
A. Yes.
Q. -- for their involvement?
A. Right.
Q. And I assume that there is a relationship between your public health agency and ADM, continuing relationship?
A. Yes.
Q. So did they reach out directly to Mr. --
A. Nixon.
Q. -- Nixon?
A. I don't know.
Q. Did you ever talk to Mr. Nixon about the formation of the task force?
A. No, I did not.
Q. So let me make a statement, and let me know if you agree with it. Prior to 2015, you were aware of the task force, but you weren't involved, and then you became involved with it after you became health commissioner?
A. True.
Q. Are you aware of the -- I might not get this right, but youth behavioral risk

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survey --
A. Yes.
Q. -- that was done in 2013?
A. Yes.
Q. Was that something you were involved in planning or executing for Summit County Public Health?
A. Finding money to pay for it. Planning it and finding money and getting the contractor on board, Case Western Reserve University.
Q. So you were part of the planning process?
A. Yes.
Q. Seeking funds?
A. Yes.
Q. Were you actually involved in going out and retaining the outside agency that was going to perform the study?
A. Actually, it was a bid that was put out. I was familiar with Case Western's work in Cuyahoga County, since we did it when we were there, and they have an ongoing relationship.
We weren't necessarily going to pay

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for our own youth risk behavior survey, but the State of Ohio came out and said they were only going to do 50 children in Summit County, for the entire county, and that would not have been a large sample size, and the ADM board and -- or there were are a lot of people from public health and ADM involved.
And we decided we needed a good baseline sample. We did not have a good baseline sample for risk behaviors in children, youngsters, either through middle school, through high school.
So we both went back to our respective wherever, found the money, came back together again and said, let's go ahead and do this.
Q. Once Case Western was on board to perform the survey, did you have any continuing involvement in the survey?
A. Actually, we met -- I had two meetings. We met with the superintendents group to talk about the importance of implementing this in their schools, and that was under my hat, of like the quality of life, you know, the assessment piece we were doing to

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try to keep.
And then also we met with -- I met with the Copley PTA, because they were upset that the administrators wanted to take all the sexual behavior questions off, and the parents did not want the sexual behavior questions taken off.
So I met with them, those were my two meetings, other than meeting with Case, to get their bills paid or to get that sort of stuff. But that was the idea of hiring a contractor, that they would be able then to come do the program for us.
Q. And once Case was on board to perform the survey, did anybody from Summit County Public Health or ADM actually -- was anyone from those organizations actually involved in conducting surveys, reviewing data?
A. Yes. A lot of us were, in that we looked at the -- I'm trying to remember. For the first time we did the survey, there may have been some employee volunteers that went to the classrooms, because at first it was paper, and a couple of schools, because they couldn't use the Scantron sheets, so we may have had

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some employees volunteer to do that.
And then what was probably more important was, in order to get it funded, we had to agree to put some gambling questions on, because that's where some of the money came from. So we did add the gambling questions.
And then the data came out. We wanted Case to be the owner of all of the information and the data, and they were the owner of all that material. So we then received only aggregate reports from them after that. So we reviewed the data they provided to us, but it was all aggregate.
Q. And you specifically, at the time -- well, let me take a half step back.
When you say, "The aggregate information," are you talking about the report, for example?
A. Yes.
Q. Did you yourself review the report?
A. Yes.
Q. Has there been any updated research done since 2013, when that survey was performed?
A. We are launching it. It starts

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September this year again. We do it every five years. It's what we can afford to do. So -- and we wanted enough of a time period where some of the interventions that were put in place, maybe we could see some of the behavior changes. So it will start again in September of 18.

Q. Is it going to be the same subject matter areas?

A. The youth risk behavior survey is validated. It is a CDC product. There is only -- you have to have a core set of questions, and then you can change a few, a percentage, but if you change too many, it's no longer comparable to other areas and other regions.

So we abide by all the statistical analysis rules, to make sure we are not going to screw up the sample. So Case will decide that. We will tell them areas that we want to question in, but they will make sure that it stays within the validity of the survey.

Q. And you anticipated my next question, which was going to be, is Case performing a study as well?

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A. Correct. They are about the only ones in town that will do it now, because it is very labor intensive.

Q. Now, you mentioned CDC. Does the CDC also perform these studies on a national basis?

A. Well, they used to do it a little better. They used to get a company, and then they would contract with the states. Well, every three years, the vendor has to turn over, by rule. So they had to get a new vendor.

So they got a new vendor, and then each of the states didn't like the new vendor. So some of the states went with that vendor, some didn't, so it is kind of a real hodgepodge out there now, but the CDC does do the risk behavior surveys.

Q. And they had done them, for example, prior to 2013?

A. Oh, yeah.

Q. When you were planning this project on behalf of Summit County, did you review the CDC's prior reports on --

A. Oh, I have always seen them. We don't -- and this isn't meant to be

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derogatorily stated, but we don't pay much attention, because they don't have a big enough sample size.

I mean, it's great if you are looking at youth across the country, but it's not if you are trying to figure out what's going on in your own community.

And if the sample sizes aren't big enough, and the Ohio Department of Health never had the money to do a big, full scale, so they did these very small samples, and, unfortunately, they couldn't even tell us where the samples were from.

So we don't know who we're talking to or what their -- statistically, it's great for the whole state, but it is not drillable. You can't drill down small enough to know if it really applies to your county, if that makes sense to you.

Q. Yeah, it does, and my recollection from that report is, and we can pull it out if we have to, but there were roughly 18,000 students that were surveyed?

A. Yes.

Q. So are you telling me that, for

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example, when the State of Ohio did it, they didn't have enough --

A. They were going to do 100 kids.

Q. From who knows where?

A. Yeah.

Q. You mentioned seeking funds for the project. I don't recall if I asked or if you told me already, but where did the funds come from that they --

A. It was grant money.

Q. From the State of Ohio?

A. No, no. It was local funds. It was from the quality of life project, and we had some carryover from the year before, so we used that, which is all local money.

Q. And was 2013 the first time that you are aware of that Summit County performed a survey like this?

A. On our own we did it, yes.

Q. What existed prior to that that wasn't on your own?

A. We just used the state survey.

Q. Which you have some issues --

A. Right.

Q. -- regarding the quality of the

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data?
A. Correct.
Q. Okay. Turning back, a little bit back towards your --
THE NOTARY: She was talking at the same time he was. Did you object?
MS. KEARSE: Form objection.
Q. We had run through your education, your training on substance abuse issues. Have you undertaken to educate yourself on FDA regulations?
A. Some.
Q. What FDA regulations have you looked into or educated yourself on?
A. Locally -- well, it's probably more state law than FDA, are the OARRS requirements, and some of the regulation about what should happen when there is a distribution of opioids.
And a lot of that came through emergency preparedness, because we are required -- we were looking at just in general for -- we are required to keep a stockpile of antibiotics, and we were debating whether we should do that again, because it was so expensive.

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And like at the time doxycycline and Cipro were so expensive, and we purchased it, and like it was going to go -- it was going to expire, and we couldn't use it.
And it was killing me that I knew these free clinics and everybody was struggling, and these drugs would have been so helpful.
So we were looking into the FDA regs about, you know, can we use these, is there a longer-than-life expectancy, are they really good still but we -- because we couldn't afford to replace them, with the stockpile.
So when we were doing that, we were reviewing other requirements for FDA, and one of the things we came -- I was reading about, I remember reading about is, you know, there are certain rules and regulations about how you distribute opioids and what you do and who you got to call and what you got to tell them when you do these things, these distributions.
Q. And I want to make sure we are talking about the same thing, because I had asked you about FDA regulation, you said yes, but then you said, well, maybe they were state

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and OARRS or --
A. Well, OARRS, I also looked at all the OARRS requirements about reporting. So that is state rule.
Q. Right. Okay. So I just want to make sure we are not talking about two different things.
A. No. I'm talking about the FDA with the Strategic National Stockpile, and then I was reading about the rules, and OARRS was separate.
Q. So the opioid regulations, you were not referring to FDA regulations, you were referring to the State of Ohio OARRS --
A. OARRS, but no, no. Then when I said about we were looking at FDA rules around this Strategic National -- that was FDA rules.
Q. Are those opioid related?
A. Well, then I stumbled across it and kept reading about how you were supposed to tell if you download -- if you sent a bunch of drugs to an area, you should tell somebody you were doing that, and all of those rules around who you had to notify and what had to be notified.

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Q. Okay. And are those FDA regulations or are they perhaps DEA regulations?
A. They may have been DEA. Now that you say that, you could be correct.
Q. When, roughly, was this that you were looking into it?
A. It would have been about a year ago, maybe two. Because those drugs expired, and we only bought enough for the safety forces, to start.
Q. And if I were to ask you questions, and one of my colleagues may later in the day, about what those requirements are for notification, so who has to notify whom, would you be able to talk about those in --
A. No, because I was just reading about it and remembering that when you said that to me.
Q. All right. Going back to the FDA regs, have you ever read anything regarding the new drug approval process?
A. Yes.
Q. And what have you read about that?
A. Just the process to you get drugs

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approved, but it wasn't because of opioids.
Q. Okay. Would that be something that you would feel comfortable standing up in front of your public health colleagues and lecturing on?
A. No.
Q. Have you reviewed any of the FDA regulations related to approval of generic drugs?
A. No.
Q. How about the process for implementing or changing warnings that come with, for example, opioids?
A. No. I would have no reason to.
Q. How about any FDA regulations regarding the advertising or promotion of FDA-regulated products?
A. No. Again, I would have no reason. We don't --
Q. Other than the DEA regs or the regulations that might have been DEA regulations that we talked about just a moment or two ago, anything -- any other DEA regulations you might have read regarding --
A. The only one that comes to mind is

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I did read about dump boxes. We do the, you know, the drug disposal boxes.
We wanted to expand the program, and I was reading the DEA rules around that, they have to be under direct video surveillance, and it has to be a police force, there has to be an actual police force.
So we just couldn't put dump boxes all over the community, which is what we wanted to do, and that they had to be tied to either a police department, a real police department, not like a security at the mall, and they had to be under video surveillance.
Q. How many of those dump boxes are there in Summit County?
A. I think we have 15 now.
Q. And so if I'm hearing you right, they all have to be under video surveillance and located at a legitimate police force site?
A. Yes.
Q. Is that program run by Summit County Public Health?
A. Yes.
Q. And who funds the maintenance of those dump boxes?

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A. We do, out of general revenue.
Q. Is there a number per box that you can cite to us for administration?
A. You mean the cost?
Q. Yeah.
A. Well, the whole program cost us about 40,000. Most of that is incineration though. We have to burn, the medications have to be incinerated.
Q. And 40,000 per year?
A. Yes.
Q. And those dump boxes aren't specific to just opioids, correct --
A. Correct.
Q. -- they are any pharmaceuticals?
A. Oh, yes. Yes.
Q. When did Summit County install or start installing those boxes?
A. 2005 maybe, 2006.
Q. So we were talking about DEA regs. There was the distribution, you mentioned, five minutes or so ago, and then the regulations regarding these dump boxes. Any other DEA regs --
A. No.

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Q. -- you looked into?
A. No.
Q. I have one -- tie off one last thing, I think, on general background, and we were talking about Summit County Public Health's budget roughly after the merger with Akron and how it had changed.
You were able to put a -- you told me that there was about one and a half to 1.7 million dollars spent or budgeted in 2018 for substance abuse programs?
A. Yes.
Q. Was that just one -- was that just the portion of grant money that has been received by Summit Count Public Health, or was that the total budget?
A. That was everything in the counseling. That didn't include the dump program.
Q. So out of the roughly 24 million pot, or revenue, that Summit County Public Health has in 2018, that was the slice available for substance abuse counseling?
A. No, not exactly.
Q. Okay.

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A. Because we only have about 12 and a half million in grants. The rest of that money is pretty much designated by state rule. So the 12 and a half we had, about a million and a half went to the substance abuse programs.
Q. And of the roughly 12 million in your agency's revenue that isn't from grants --
A. Right.
Q. -- can you put a number on how much of that goes towards substance abuse programs?
A. Well, I can kind of add up in my head. We have about 40 in dump, about 65 for the STARS program, that's about 105 that we have committed. We do buy some naloxone. I don't know how much that is, maybe 5, 10,000. We do buy fentanyl test strips, that's another 5,000. So maybe 125, is that where I'm at? Something like that.
Q. And the grant money comes from federal, state and/or private sources?
A. Usually federal, state, local.
Q. Okay.
A. But many local foundations don't fund government, because they know we receive subsidies.

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Q. And there was a program you were describing, I think it was for the -- how ADM reimburses for certain substance abuse services provided to maybe indigent or underinsured patients?
A. Correct.
Q. Where in the budget does that get allocated? That's not considered a grant, is it?
A. No. It's a contract.
Q. So again, if you are looking at a pie chart, it would be separate from the 12 and a half million?
A. Yes. We are mandated to keep every federal project separate, particularly if there are any FDA numbers attached, everything is kept totally separate.
Q. And who would be the person most knowledgeable in your agency regarding the revenues and expenses, sources of revenues and where that money goes for substance abuse programs?
A. Probably Jackie Pollard. Jackie would have an account clerk assigned to her, that would help her with that, but they

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wouldn't know a lot of the particulars.
Q. Is there -- is there somebody at the administration level that handles the inflows and outflows of expenditures for the agency?
A. Yes.
Q. Who is that person?
A. Well, it's Angela Burgess is the fiscal officer, and then there are six, five or six account clerks.
Q. And they are assigned to subject matter areas?
A. Yes.
Q. Okay. And that being the different divisions within the department or the -- there would be one assigned to each one of these divisions in Exhibit 1?
A. No. It depends on the load of the grants. So it's basically based on the amount of the grants, the cumulative amount of the grants.
So if you have like two -- our HUD grant is 2.5 million for lead abatement and housing repair. So if you had lead and you had, let's say, ADM board, 700,000, that's

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close to 3 million, then everybody would -- they would distribute -- so you could have another 3 million over here, but you might have 10 grants in that 3 million. It's really based on more money.
MR. NAEEM: Why don't we go off the record.
THE VIDEOGRAPHER: Off the record, 12:09.
(Recess taken.)
THE VIDEOGRAPHER: On the record 1:00 p.m.
MR. NAEEM: I think that we need to make sure that people on the phone identify themselves, in case some people dropped off and some people joined.
So could you please give us a rollcall of who is all present on the phone? Do we have people on the phone?
MR. FRANCO: Joe Franco, with Holland & Knight, for Insys Therapeutics.
MR. BROWN: Elliott Brown, from Morgan Lewis, for Teva.
MR. RUIZ: Anthony Ruiz, Zuckerman Spaeder, for CVS.

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MR. RAIOLA: Stephen Raiola, with Covington Burling, on behalf of McKesson.
BY MR. NAEEM:
Q. Ms. Skoda, I'm not sure I remember where we were when we left off.
A. You were going to a new subject.
Q. Yes, I am going to go into a new subject.
MS. KEARSE: And he will ask you the same questions.
Q. We can start at the top, with education and training, but I would like to move on to the opioid crisis and specifically here in Summit County.
We talked at length about your agency and your knowledge regarding opioid addiction issues. When did you become aware in -- or when did you become aware of prescription abuse issues that were occurring in Summit County.
A. During that 14 to 15 time period, I was probably -- or I was, not probably, I was aware that the Opiate Task Force was beginning. The data was starting to tick up. We were looking at many, many data sources. We were

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starting to have, you know, the overdoses, the pill mills, those sorts of things.
So I was aware of it. Not my direct responsibility, so I wasn't really that involved.
Q. So you didn't have any responsibility within the agency for handling these issues, but as an employee of the agency, you may have been generally aware; is that fair?
A. Yes.
- - - - -
(Thereupon, Deposition Exhibit 3, Youth Risk Behavior Survey, High School Report, was marked for purposes of identification.)
- - - - -
Q. Ms. Skoda, I'm going to hand you what has been marked as Deposition Exhibit 3.
A. Oh, okay. Number 3.
Q. Now, can you identify what Deposition Exhibit 3 is?
A. It is the Youth Risk Behavior Survey, High School Report, summary report.
Q. And this is something that we

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talked about earlier that you had some involvement in the planning for?
A. Yes.
Q. And do you recall having received and read this report?
A. Yes.
Q. Do you recall, as we sit here today, and we will look at it, but do you recall what the results of the survey were regarding prescription drug misuse by teens in Summit County was at this time?
A. Yes. My recollection, in this report, was we were concerned, and when I say "we," I don't mean just me, it was the health department and the Opiate Task Force.
There was conversation about the kids needed to have resiliency skills built, and that was in relationship to the suicide -- the three areas that I remember clearly, that stick out in my mind, were the suicide, those individuals who felt depressed more days and severely depressed, and those individuals, those youngsters, that had tried suicide was a fairly significant percentage. The exact percentage escapes me.

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It also talked about youngsters who had used somebody else's pain medication, which again was concerning, because there seemed to be a perceived acceptance that that wasn't harmful, because it was somebody else's legitimate medicine.
So the ADM board launched any number of programming, put out some grant moneys in the schools, for zero -- for suicide prevention, as well as -- it's something called the PAX Good Behavior Game, it's P-A-X, all capital letters, and what that is, PAX Good Behavior Game, works with teachers to talk about how to build resiliency in kids, how to have behavior controls, those sorts of things, in the classroom. And they did that, and school districts took advantage of those grant moneys.
Q. And I want to be clear about what you just said. Those programs occurred because of the results of the survey?
A. Yes.
Q. Now, prior to the survey -- well, first of all, you had testified earlier that this survey is based on a methodology --

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A. Yes.
Q. -- a validated methodology developed by CDC?
A. Correct.
Q. So was there any analysis done by Summit County during the planning phase to emphasize certain aspects of this survey based on local conditions?
A. No. We are not allowed. Like I said, we talked about some of the conditions. We did add gambling questions, but there is a core set of questions you have to ask. This survey is developed to be from that research.
Q. And was there any discussion in the planning phase about certain issues that were perceived to be ongoing in Summit County that would be interesting to find out what the actual results were in this cohort?
A. Not that I remember.
Q. If you could turn to, and these are numbered a bit weird, but there is a section 6, page 12.
A. Yes. Okay. Okay.
Q. Are you there?
A. Yes.

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Q. Okay. What does this table represent?
A. Let me take a minute and look at it. It is comparing, I believe, what was on the other pages in regards to prevalence, to the number -- the percentage of individuals to the now -- the Ohio and the United States numbers.
Q. And what are they specifically looking at, in this table?
A. It looks as though there are one, two, three, four, five -- 13 indicators.
Q. And those are for illegal drug use or substance abuse?
A. Correct, substance use.
Q. Substance use, okay.
And was one of the things they looked at prescription drug use?
A. Well, just the one question about have you ever used somebody else's medications.
Q. And --
A. -- without a doctor's prescription.
Q. Right. So the actual category that was measured, and so this would be a question that was asked of everybody who participated in the survey?
A. Yes, providing the school district didn't remove that question, and to my knowledge, none of the questions regarding any sort of substance use were removed. It was only occasionally sexual risk behaviors that were removed.
Q. We certainly have results here about -- the results, or at least the answers to the question about whether the survey participants, and this is in quotes, "Ever took prescription pain medication without a doctor's prescription," end quote; do you see that?
A. Yes.
Q. And that would be improper to do so, correct, to use prescription pain medicine without a prescription?
MS. KEARSE: Objection.
A. Yes. You aren't supposed to.
Q. And what was the result of the survey for that particular question?
A. 15.6 percent in 2013 alleged they had done that.
Q. So 15.6 percent of the --
A. Participants in the survey.

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Q. And this is kids of high school age generally?
A. Middle to high school. This was -- oh, this is the high school report. I'm sorry. Yes, it is high school.
Q. But 15.6 percent of kids who took the survey were using opioid medications without a doctor's prescription, correct?
A. The question -- okay. I'm not sure what you are asking.
I think I get what you are saying to me, but if I read this, it's, "Ever took a pain medication without a doctor's prescription," and so the kid either answer, I believe, yes or no.
Q. Okay. And 15.6 percent of them --
A. Said yes.
Q. -- said yes.
And there is a number of other drugs that are listed here, in addition to prescription pain medications being used without a doctor's prescription, yes?
A. I'm sorry. Could you repeat that?
Q. Yeah. There are a number of other substances that are being tested in the survey

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and measured regarding whether the youth that took the survey were using these substances and how many of them were using them?
MS. KEARSE: Objection.
A. Yes.
Q. And, for example, the results in 2013 for Summit County use of marijuana one or more times during your lifetime was 36.6 percent?
A. Yes.
Q. Cocaine use was 5.8 percent?
A. Correct, yes.
Q. Heroin use, 4.1 percent?
A. Yes.
Q. Methamphetamines, 5 percent?
A. Yes.
Q. Hallucinogenic drugs, 8.9 percent?
A. Yes.
Q. And those drugs that I just mentioned, those are all illegal substances?
A. Yes. To my knowledge, yes.
Q. So what does that data tell you about the prevalence of drug use in Summit County, if anything?
A. I'm --

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Q. Let me ask it a different way.
A. Please.
Q. Would you agree that this data indicates that there is some portion of the population that is going to abuse drugs no matter what the drug is?
MS. KEARSE: Objection.
A. My answer to that would be no, it doesn't tell me that. What I take from this data is children experiment, youngsters experiment with substances.
Q. And how is that different from what I asked you?
A. Would you say what you said again?
Q. Sure. What I asked was would you agree that this data shows, or demonstrates, that some proportion of the population is going to use illegal substances, no matter what the substance is?
MS. KEARSE: Objection.
A. I think I have trouble with the words, "Going to use." I don't know if youngsters start out with the intent. They are experimenting with drugs. I don't know if it is, "Going to use." I don't know if they are

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set on a pathway and a certain group of them are always going to do drugs.
Q. Well, this country has had a long history of substance abuse going back to the late 1800s, at least; would you agree?
A. Yes, I would.
Q. And you have seen articles about heroin and morphine use in the 1800s and addiction issues from articles written in the early 1900s, yes?
A. Correct, yes.
Q. So this isn't a new issue in this country?
A. Yes.
Q. Opioid abuse is not a new issue in this country?
A. I would say in the past, I think it was very different.
Q. How so?
A. Opioids, we never had in the past. Opiate use was mostly -- back when I was a parole officer and back when I was in the inner city of Cleveland, heroin use was used by a very certain group of individuals.
What we see now -- and that may

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have been a group of individuals that started out by, you know, being 12 years old, smoking a little bit of pot, ended up going on to a much more serious drug addiction, having a substance abuse disorder.
What we see now though is a group of folks who may have innocently started out by taking a pain med, having a surgery, being harmed, and then having this horrific supply in the community, be able to become very addicted very quickly, and have ease of access to those drugs.
And it was one of the reasons in 13 and 14 that Jerry Craig was so adamant about we need to get a baseline survey, we need to find out just exactly what youngsters are thinking and their risk behaviors, because I think we were worried that there was a changing -- the heroin addict of old, who had a little tattoo right here that told them exactly how much heroin to use so they never overdosed, was gone. They're different now.
So the whole scene was changing, and it was taking -- it was a very hard thing to get your hands around, but it was becoming a

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very different user. It was coming across our paths.
Q. Now, what I thought I heard you just say was, in profiling those new users, was that these were people who had been legitimately, perhaps, prescribed opioids and were becoming -- or the prescription opioids and becoming addicted?
A. Could have been.
Q. Could have been?
A. It's one pathway.
Q. Now, have you seen any data regarding -- seen any data that allows you to characterize what percentage of opioid abusers started on that pathway?
A. I can tell you from the Opiate Task Force work, what we have been told is it is four out of five or about 80 percent have reported starting with a prescription pain medication.
Q. Okay. Does that data tell you whether they legitimately had a prescription pain medication?
A. I don't know that.
Q. Okay. You understand the

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distinction I'm trying to make --
A. Oh, yes, I do.
Q. -- because four out of five of those could have stolen them from their family's medicine cabinet and never had a legitimate prescription; would you disagree?
MS. KEARSE: Objection.
A. Yes, I agree with that, but it shouldn't have been in the medicine cabinet to begin with. There was such an oversupply available in the community, it was just anywhere you went. I mean, it was out there.
- - - - -
(Thereupon, Deposition Exhibit 4, Email Exchange, Beginning with Bates Label Summit 154701, was marked for purposes of identification.)
- - - - -
Q. Ms. Skoda, I'm handing you what has been marked as Deposition Exhibit Number 4.
A. Thank you.
Q. Before we turn to this exhibit, let me ask you, you were talking about an oversupply. What's the basis for your testimony that there was an oversupply of

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prescription opioids that was leading to addiction issues?
A. I think it's twofold. One is self-reported from individuals that we have come in contact with, that we have treated, that have said, you know, there was a lot available. I have actually talked to users who thought they were buying legitimate oxy in the street, a little blue pill, and it ended up being fentanyl, and they have subsequently overdosed.
But the other part of it is, again, our OARRS data, you know, was indicating, again through the Opiate Task Force, that we were tracking high amongst -- the pills that were dispensed per person in Summit County was just really high, and the State of Ohio was telling us to pay attention, and the programs that we were focusing on needed to get that per-person number down of dispensing.
And particularly there was some information, you know, provided in grant projects that we wrote about we want to get the morphine equivalents down. There is too much in the community.

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Q. Okay. So with respect to the pills dispensed per person, that was a goal that was set by the task force was to reduce?
A. Yes.
Q. And as part of any work you did with the task force or on your own, what was the -- what was leading to the -- what was causing the high amount of pills dispensed per person? Why was it a number that needed to be decreased?
A. I think because the availability was there. It was in the community. Not everybody was taking all of their pills, or those that were taking them were not getting pain relief and taking a higher dose, were either subsequently becoming addicted and taking a higher dose and/or leaving their extra pills just lying around, and it did fall into the wrong hands.
Q. All right. So the situation where people wouldn't have been taking all their pills and would just leave them around where somebody else could pick them up, that would be diversion, right, somebody who took the pill from somebody else?

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A. Yes.
Q. Other than diversion, were there any other reasons why these pills were more available than perhaps they had been in the past?
A. It is my belief, and I know that when pain was starting to be a fifth sign, and all the focus was, you know, directed towards nobody can be in pain, all of the pain meds that were historically used for the end of life, cancer treatment, hospice care were being dispensed for headaches, back pain, because the physicians thought they were doing what they should be doing, based on what their medical societies were telling them, with pain as a fifth sign.
So when all of those pills started to flood the market, you know, people were using them, they were out there for any number of conditions, that they typically, in the past, never were for.
Like if you had ask me 12 years ago in public health, I would have -- or even a home health nurse would have never known that there were the level of narcotics that were in

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the home that there is now.
Q. Okay. And are you aware -- you mentioned medical societies in your answer, that physicians were doing essentially what their medical societies had told them, with respect to treating pain.
Were there any State of Ohio initiatives that encouraged the use of opioid medications that you are aware of?
A. Not that I'm aware of.
Q. Do you recall Ohio law changing, regarding use of opioids for intractable pain?
A. No.
Q. Were there physicians who were engaging in illegal or immoral conduct in providing opioid medications to their patients?
MS. KEARSE: Objection.
A. I would know of none of those, other than the ones that were in the newspaper that were subsequently arrested and convicted.
Q. And what were the circumstances of those generally, you don't have to recall the specifics, but what was it that doctors were doing?
A. Well, I think disregarding

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protocols. I think a few were disregarding protocols, not getting appropriate follow-up with patients, following any standard of care, just basically writing prescriptions, is my understanding of the one that I know about.
Q. What are you specifically referring to?
A. That was arrested.
Q. When was that, do you recall?
A. No. I know he was out of Copley, Ohio, but I don't know when. It was a while ago.
Q. Yeah. Have you heard the phrase "pill mill"?
A. Yes.
Q. What does that mean to you?
A. It's a -- it's a group of individuals that are licensed to prescribe in Ohio, whether they are physicians or whatever their specialty might be, that operate under pain management clinics, yet disregard any standard and just continue to dispense pills, without any follow-up or, I think, appropriate treatment guidelines.
Q. And to your knowledge, were

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physicians who operated pill mills, do they contribute to the increase in prescription opioids available for abuse?
MS. KEARSE: Objection.
A. Probably some. I think anyone who overprescribed was contributing.
Q. Do you have any sense or do you know how many physicians have been prosecuted in Summit County for operating pill mills?
A. No, I do not.
Q. Have you heard of online pharmacies?
A. Yes.
Q. Have you done any research or heard about whether online pharmacies -- the operation of online pharmacies contributed to the opioid prescription use epidemic?
A. No.
Q. Do you know how online pharmacies operated, do you have any information about that?
A. Not for opioids. I buy dog medicine, but that's not opioids.
Q. No. So as we sit here today, you don't have any information regarding whether

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people were obtaining prescriptions improperly through online pharmacies?
A. I know that anecdotally people have said that, but not that I know for a fact.
Q. Is that something that was discussed at the task force level or --
A. Not that I remember.
Q. You did mention overprescribing, physicians were overprescribing opioids --
MS. KEARSE: Objection.
Q. -- to their patients?
A. Yes.
Q. What about patients, were you -- are you aware of any conduct by patients generally, not specific patients, that contributed to the increased availability of pills, opioids, on the street?
MS. KEARSE: Objection.
A. Their behaviors were driven by a brain disease addiction. So once they became addicted, they continued to seek drugs, and that may have included behavior such as doctor shopping or forging prescriptions or stealing medication, but I believe that's, you know, just an unintended consequence of getting

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addicted to a medication.
Q. And those patients who were forging prescriptions or stealing medications, did they always -- did they always use the medications, or did they perhaps sell them on the street?
MS. KEARSE: Objection.
A. I can't -- I don't know.
Q. That's not something that you have heard discussed?
A. Oh, I've heard that, and I have heard that people sell medications to survive. Just like food stamps have value, pain pills have value. There is a whole separate economy in the streets. So, yes, they are used for income, they're cash.
Q. Okay. And --
A. -- in supporting a habit.
Q. And I had previously marked Deposition Exhibit 4. Did you get a chance to look at that?
A. Yes.
Q. Who is Terry Albanese?
A. Terry Albanese was assistant to the mayor for education, health and families. She is no longer there.

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Q. Is she in -- I'm sorry. Is she still in the City of Akron government?
A. No.
Q. Is she working for Summit County government?
A. No, not to my knowledge.
Q. And do you recall this email; is this something you recall?
A. Yes. I remember reading it.
Q. And you were attached -- I'm sorry. You were one of the recipients of this email, correct?
A. Right.
Q. So this email is dated September 7, 2016. Do you see the second paragraph?
A. Correct. Yes.
Q. And it is referring to Governor Kasich, one of his --
A. Right.
Q. -- responses to the opioid crisis, yes?
A. Well, the first paragraph is. The second paragraph --
Q. Right. And so she says, she is talking about people under the age of 18 and

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the percentage of overdoses in that age group?
A. Are small, correct.
Q. Right. And then she goes on to state, "However, I have yet to see any research on when and how overdose victims got started with substance abuse in the first place. If any of you have data along those lines, I would be quite interested in the findings."
Was there any response to Ms. Albanese that you were copied on?
A. Not that I remember. And I was trying to remember if I responded to her, and I don't believe so. I don't know. I may have sent her the risk behavior, but I don't remember. There might be.
Q. So you may have responded and you may have sent her the youth survey?
A. Right.
Q. But you don't recall?
A. But I think she probably already had that.
Q. And was there anything else you might have sent her about when and how overdose victims got started with substance abuse?
MS. KEARSE: Objection.

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A. Not that I remember.
Q. Was there anything that you saw sent to her by any of the people who were copied on this email?
A. Not that I remember. I was looking at the list of names and thinking who might have responded, but, no.
Q. And so you don't recall whether anyone might have sent her anything regarding how people get started on prescription opioid abuse?
A. No.
Q. In talking about prescription opioid or, I'm sorry, opioid abuse -- strike that.
Is opioid abuse something that's tracked by Summit County Public Health currently?
A. Yes. Well, I should say opioid data that we have access to is tracked.
Q. Okay. And so you made the distinction about data that you have access to.
A. Correct.
Q. What is the data that Summit County Public Health has access to?

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A. We have access to birth and death data, we also have access to the coroner's data via ADM board, alcohol, drug, mental health. We use some of the ADM data that they give us, and we also have access to something called EpiCenter.
Q. Other than those sources and data, is there any other data that your agency monitors with respect to opioid use or perhaps overdoses?
A. No. We don't have access to either clinical data, OARRS, or any of that. We are not allowed to have access, it's public -- it's PHI.
Q. All right. So nobody at Summit County Public Health has access to OARRS?
A. Our medical director, but only for her patients.
Q. Which does or doesn't include --
A. MAT?
Q. Well, I was going to ask about any Summit County Public Health program, but --
A. No, she does not.
Q. So even with the medical-assisted treatment program participants, she would not

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be able to access OARRS; is that correct?
A. Yes.
Q. So the birth and death data, what about that data would inform you regarding use of -- use, misuse of opioids or overdoses?
A. Cause of death.
Q. So the death certificate will have information regarding what that patient -- or what that person died of?
A. Yes.
Q. And does your department keep statistics of those causes of death?
A. Yes.
Q. Who is responsible for that?
A. Rich Marountas. And also, I would like to add, the birth certificate also has a part of a birth certificate that is confidential to everyone. It talks about maternal risk behaviors during pregnancy. So it does include topics of alcohol and a few other things, so we might be able to know, but my understanding the State of Ohio is doing away with that, so that may have been a thing of the past.
Q. Specifically you are talking about

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the section of the birth certificate --
A. Yes, that was confidential.
Q. How is the death certificate data that you just talked about different from the coroner data you mentioned as additional sources of information?
A. We get all of the data from the State of Ohio. There is about 6,000 births and 6,000 deaths every year. So every single person who dies in Summit County, we get that information on.
The coroner gets a subset of that group, which are those individuals that either died during a police matter, a suspicious death, somewhere where there is an autopsy required.
And so within that subset of her data, she is capable, with some difficulty, of collecting, you know, the type of drug, what killed them, that sort of stuff.
Q. Okay. So essentially the data the medical examiner gets are really only those deaths that are referred to her office for investigation?
A. Correct. And we receive that data

only deidentified. As public health, we aren't as interested -- we aren't interested in the one person, the individualized. We keep those records deidentified. We are very much interested in the aggregate data and the impact it's having on the community.

Q. Okay. So then in what format do you get that data from the medical examiner?

A. We get it via the ADM board, the coroner gets it from her. We get it as aggregate data, 25 overdose deaths, ten heart attacks.

Q. So is it via email?

A. Oh, I'm sorry.

Q. Yeah.

A. It's from an FTP site, a transfer protocol, file transfer protocol, that's secure.

Q. And how periodically do you get that data?

A. Rich probably -- I don't know exactly, because we look more at EpiCenter, he looks at that data, I would say at least once a month.

Q. And you are getting all of the

death data for that -- not holding you to it being a month, that you get it every month, but are you just asking for drug overdose data, or is it all the death data from the medical examiner that you are receiving?

A. We are asking for a combination, everything.

Q. Have you -- when is the last time you saw that data provided by ADM, based on medical examiner data?

A. I've never directly looked at it. I've only seen it written in reports.

Q. And is there a standard report format that is being prepared, based on that data?

A. Rich -- well, Rich uses that data to validate what we see in EpiCenter. So EpiCenter is a realtime surveillance system that was established after 9/11, and it was established to allow health departments to do monitoring of emergency room activity, to see if, in fact, there were any upticks in any of the disease conditions for which people present to the ER.

So if, for an example, if there are

25 people at one hospital system going in for diarrhea, and there is 25 at another system, chances are that's a real uptick in what is happening. There could be a food-borne outbreak, there could be something going on.

Move up a few years, we have used that always, and the State of Ohio sends out alerts to let you know that there is this, sort of, uptick in the data.

Rich started looking at EpiCenter all the time because there were so many overdoses in there, and we started monitoring it, and then he started putting out every day a daily overdose report, but because that data is preliminary, because nothing has been confirmed by the coroner's office that, in fact, yes, this was a drug overdose, yes, in fact, it was an opioid, yes, in fact, it was carfentanil. Unless it states an 89-year-old man died of insulin, took too much insulin, we would never include that in there.

Then Rich uses that data that we get from the coroner's office and ADM board to validate that, yes, in fact, we have the numbers right.

Q. So does the EpiCenter reports -- or does the data received from Epicenter tell you whether those overdoses were opioid related or not?

A. Sometimes.

Q. Could they be, if you were looking at an EpiCenter report right now, could you distinguish between those related to cocaine versus those related to an opioid?

A. No, not until toxicology is back.

Q. And that's data from the medical examiner's office?

A. Correct.

Q. Okay. So if we are just focusing on EpiCenter, would it tell you which substances were -- which opioid substances were involved in that particular overdose?

A. It will -- sometime it will say an opiate, because they'll use Narcan and it will be reversed, and the emergency doctor will feel comfortable saying that.

Or a paramedic will say, you know, this was an opiate overdose, we revived him with Narcan, and they will feel comfortable writing overdose/opiate, but we don't know the

type that is underneath that. It could have been carfentanil, fentanyl with opiates or cocaine. We don't know.

Q. And then going back to the medical examiner data.

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(Thereupon, Deposition Exhibit 5, Email with Attachment, Beginning with Bates Label Summit 264062, was marked for purposes of identification.)

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Q. Handing you what has been marked Deposition Exhibit 5. Did I give you the right one? Yes, number 5.

MR. NAEEM: I'm going to mark this one too.

Q. Handing you what has been marked Deposition Exhibit 6.

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(Thereupon, Deposition Exhibit 6, Email, Subject Data for Narcan, Beginning with Bates Label Summit 263018, was marked for purposes of identification.)

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Q. I actually marked them out of order.

If you could take a look at Deposition Exhibit Number 6.

A. Okay.

Q. This is a June 15, 2016 email from Rich Marountas to you; do you see that?

A. Yes.

Q. Now, those charts that are in his email, do you know how those were generated, from what data source?

A. No, I could not say for sure.

Q. Do these look like the data he sends around in his Epicenter reports?

A. No. I mean, they are similar. I'm looking at them again here. The word that is throwing me is the, "Drug poisoning deaths," which makes me believe it includes other drug poisoning.

Q. Okay.

A. So I don't know. I would have to look and check the data source to see what that means.

Q. Well, okay. Epicenter wouldn't

tell you which drug -- at a high level, you can't distinguish in Epicenter whether it is an opioid versus cocaine versus anything else involved in the overdose, right?

A. Correct, unless it was specifically stated.

Q. And then if you could look at Exhibit 5.

A. Correct.

Q. This is a June 22, 2018 from Rich Marountas to you?

A. Right.

Q. He's put that data together, and my only question at this point is, would this reflect data from Epicenter, or would this reflect data from the coroner or the medical examiner?

A. Well, what he is saying here, "Deaths for 2017 may differ from other figures," because we have seen -- because I'm going only off of the count of death certificates with drug related.

So what he was doing was trying to get verification from the coroner's office, because for a while, they were so backed up on

the toxicology, it would take six to seven to eight months to actually get a cause of death to finalize the certificate.

And so the numbers tend to look like they are all over the place, because we haven't really finished -- I'm sure this was January of 18, we weren't finished with validating with the coroner's office that, yes, in fact, these were correct, and then often we have to correct death certificates.

Q. So of the sources of overdose data we were talking about that you listed, Exhibit 5 would represent overdoses based on review of death certificate data?

A. Yes.

Q. And Exhibit 6, at this point, you are not sure whether or not that is Epicenter data?

A. No, I am not sure.

Q. Again going back to the medical examiner data that's received by the FTP site, again you mentioned Rich Marountas is the one who pulls that data down. He prepares reports based on that data?

A. Yes.

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Q. Do those reports identify the particular substance at issue in those over death -- I'm sorry in those cases, those death cases?
A. If it's been validated by the coroner that, yes, that was the cause of death.
Q. And do you see those reports; does he send them to you?
A. A lot of times they are blended into other documents. I see the drug report every day, and then, like, if we are creating this for a project or somebody has asked for data, I might look at it, but I'm not his direct supervisor, so I don't usually see everything.
Q. So who is he -- who does he -- first of all, why are these reports being prepared?
A. We get requests from the community for information all the time for grant proposals, and individuals will call us up and say, hey, do you have a graph I could stick into this grant, or we provide kind of as a service to community partners, we will give them data that has been crunched so they can

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use it in a grant proposal.
Q. So does he -- does he prepare these reports on an ad hoc basis?
A. It can be.
Q. So this isn't something that is done every month by your directive?
A. No. He monitors this data. We do the -- every Friday he does a cumulative report based on what we know, but every day he does the individual drug overdose report.
Q. But those daily and weekly reports are based on EpiCenter, or are they based on this medical examiner data?
A. EpiCenter, until they are confirmed, and that's the caveat on that data. We tell them this is the rough estimates, it's the best we have, until we actually confirm it.
Q. I guess I'm just trying to get a sense of what that confirmed report looks like. What is it that is sent around --
A. Oh --
Q. -- that distinguishes between here are these preliminary EpiCenter cases --
A. Right.
Q. -- and here is the final data

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that's been confirmed through medical examiner data?
A. What would happen is Rich would send an updated EpiCenter report and say, these are the real numbers. Or when we report out, like when somebody would ask Rich for this, like we had talked about this, he would make sure he either -- either it was confirmed, or he would put the caveat on it that we don't know for sure if this is the real number yet.
But typically, when they are -- I know what you are asking. I'm sorry. I didn't answer the question.
When he gets an update, he corrects the document.
Q. He corrects the EpiCenter report or --
A. The numbers.
Q. -- the weekly report that he sends out?
A. Yes. And -- yes.
Q. And I think you said, when you were describing these three sources of data, that your agency does not have access to patient-level data?

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A. No.
Q. So at least as far as Summit County Public Health, in reviewing overdoses and deaths in the community, and if we just limit it to opioid-related deaths, let's assume it has been able to be refined to the point that you know it's an opioid, there is no way for your agency to determine whether or not that patient had prior use of prescription opioids from a legitimate prescription?
MS. KEARSE: Objection.
A. The only way that we know that, the ADM board has access to OARRS, and the Ohio Pharmacy Board puts out reports. So we are able to use that as that sort of a barometer, that individuals are receiving some of these opioids through legitimate prescriptions.
Q. Okay. And do you get data from ADM which breaks these overdoses or deaths down into categories of patients who were using illicit substances, who are using prescription opioids, and who were using prescription opioids based on a legitimate prescription?
A. Not to my knowledge.
Q. So at least you, within the agency,

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haven't seen it?
A. No.
Q. Have you talked to anybody at Summit County Public Health who has received that data from ADM?
A. Not to my knowledge.
Q. Have you talked to anybody at ADM about their ability to generate that patient-level data?
A. No.
Q. So what is the ADM data that you believe -- oh, I'm sorry. Strike that.
ADM has access to OARRS?
A. Yes.
Q. And so was your answer based on simply the fact that they do have the ability to go look at OARRS?
A. Right, and present to the Opiate Task Force their findings.
Q. Is that something you are aware that they have done?
A. Yes, in their reporting and in their presentations.
Q. Have you attended a task force meeting or subcommittee meeting where ADM has

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presented OARRS data?
A. I could not be sure. I mean, there is a lot of data presented. I just don't know the source, without checking.
Q. Would you agree with me that there are some heroin users in Summit County who have never used prescription opioids?
MS. KEARSE: Objection.
A. Would I agree with that statement, or it's more I just don't know?
Q. Either way.
A. I don't know.
Q. Would you agree with me that there are some prescription opioid abusers in Summit County who have never had a legitimate prescription for opioids?
MS. KEARSE: Objection.
A. I'm sorry. Would you ask it again?
Q. Sure. Would you agree with me that there are some people in Summit County who are abusing prescription opioids who have never had a legitimate prescription for that medication?
MS. KEARSE: Objection.
A. Again, I don't know.
Q. You are aware, however, based on

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your prior testimony, that there certainly are people abusing opioid prescriptions who have gotten them through improper means?
A. Yes.
Q. Have you done any research -- we talked a little bit earlier about some of the education and some of the programs you have attended regarding substance abuse after you became health commissioner.
Within the context of any of those programs, did you read anything or hear anything from anyone about the consequences of untreated chronic pain?
A. Yes.
Q. Okay. Are you aware that untreated chronic pain can lead to depression?
A. Yes.
Q. Are you aware that untreated chronic pain can lead -- can lead some people to commit suicide or attempt suicide?
A. No, I did not know that.
Q. Do you dispute that fact?
A. I don't know.
Q. Are you aware that untreated chronic pain can lead people to self-medicate?

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A. Yes.
Q. And that self-medication can lead to substance abuse?
A. Yes.
Q. Is it your position that opioid medications should not be available to people suffering from chronic pain?
MS. KEARSE: Objection.
A. Yes.
Q. Should not be available?
A. Yes.
Q. And what is that based on?
A. From what I've seen, with the devastation and destruction that is cause for conditions that perhaps could have been treated another way and/or been much more successful in the treatment if there had been, perhaps, another approach to pain management, that included those difficult lifestyle behavior changes that individuals can be very resistant to and/or other sorts of pain treatment programs that didn't require a prescription.
Certainly there are conditions at the end of life, hospice care, horrific surgeries, where a well-controlled pain is

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critical, but for the general use in the community, it has wreaked havoc.
Q. Who decides when opioids are appropriate for treatment of chronic pain?
A. I would hope that a physician would, or a nurse practitioner.
Q. And you raise a good point. There are different groups authorized under Ohio law to dispense or provide a prescription --
A. Right.
Q. -- for chronic pain.
You mentioned physicians, nurse practitioners. Are you aware of any other medical professionals who are able to prescribe?
A. Dentists.
Q. Anybody else?
A. I'm sure psychiatrists could. Any licensed physician in Ohio and/or an NP.
Q. Are you aware of whether or not physicians assistants --
A. I'm sorry, PAs. I forgot about them, yes.
Q. And to be fair, you are not one of those, in one of those categories --

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A. Correct.
Q. -- of people who can prescribe?
A. Correct.
Q. And are you aware of any state laws or administrative sections regarding chronic pain patients' access to pain medications?
A. No, I am not.
Q. And you initially said you don't believe that opioids should be available for treatment of chronic pain, but you carved out some of the more -- the end-of-life pain and some horrific surgery, I think you said?
A. Correct.
Q. Would you agree that restricting access to prescription opioid medications would result in some chronic pain patients who don't get the treatment they require?
MS. KEARSE: Objection.
A. Perhaps.
Q. Do you suppose that could lead to increases in depression and suicide?
MS. KEARSE: Objection.
A. I don't know. It's a conclusion that you could draw, but I don't know that.
Q. Could it lead patients to

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self-medicate with illegal opioids --
MS. KEARSE: Objection.
Q. -- like heroin?
A. Perhaps, yes.
Q. Do you believe that -- or do you dispute that chronic pain is a legitimate medical issue?
MS. KEARSE: Objection.
A. No.
Q. Have you seen any analyses at the federal or state level regarding the cost of chronic pain to society?
A. I'm sorry?
Q. Yeah. I don't know what that was.
Have you seen any data published at the federal or state level analyzing the cost of chronic pain to society?
A. No, not that I remember. I'm sure I've read it, but don't remember it.
Q. Can pharmaceutical companies legally provide opioids directly to patients?
A. No.
Q. Do you know -- you testified about reading some DEA regulations about distribution. Do you know how prescription

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opioids make it from the manufacturers or pharmaceutical companies to patients, do you have a general understanding of the process?
A. My guess, it would go to a supplier, and then to the physician -- a pharmacy for which the physician would write a prescription, and the patient would fill it.
Q. Those suppliers or distributors, as they are sometimes called, do you know if they can legally provide opioids directly to patients?
A. Not to my knowledge.
Q. Can pharmacies do so?
A. Not without a prescription.
Q. Have you read any warning information published by manufacturers regarding prescription opioids?
A. No, I have not.
Q. Would you agree with me that many substances can lead to addiction issues other than opioids?
A. Yes.
Q. What are some of those substances that are causing addiction issues in Summit County that you are aware of.

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A. Alcohol, marijuana, although there are those that don't believe it is addictive, methamphetamine, crack cocaine, cocaine, any sort of pill, benzodiazapine, any amphetamine, there are any number of drugs.
Q. And other than the general substance abuse programs we have talked about that are provided to clients of Summit County Public Health, are you aware of any task forces or any other initiatives to reduce, for example, the substance -- or addiction issues related to, for example, methamphetamine?
A. I think they are generally treated under just substance use disorders.
Q. So again, the counselors can see patients that have addiction issues, it may be opioids, it may be any other substance?
A. Correct.
Q. And I had asked you earlier about whether -- about data regarding -- strike that. Never mind.
Has Summit County, to your knowledge, assessed the link between mental illness and opioid abuse?
MS. KEARSE: Objection.

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A. I am not sure.
Q. So with respect to any causation or association between mental illness and opioid abuse, you wouldn't be able to characterize, for example, what percentage of substance abusers have mental illness?
A. No, I would not.
Q. Looking at Exhibit 5, is it a fair characterization that, the second page specifically, is it a fair characterization to state that the number of overdose-related deaths have increased year over year since 2014?
A. Until we get to 17, there is a pattern of increase.
Q. And what was, if you are aware, what was driving the increase in opioid -- I'm sorry, overdose-related deaths over that time frame?
A. I know that when there was restrictions on the number of prescriptions that started to be dispensed in Ohio, many individuals who had a legitimate source to get drugs, could get prescription pills, could no longer get them.

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Many of them went to other sources to get medications, opioids specifically, to continue their addiction, the brain disease. It's a very powerful addiction that drove individuals to do things that they normally would not have done, if they could have maintained getting those pills.
And whether it was from a physician, a pill mill, wherever they were getting them, because there was so much, when that supply was cut off, they went to other sources, or thought they were purchasing OxyContin in the street, and they were not, and they were purchasing fentanyl or carfentanil, or some other derivative.
Q. And so you started your answer by saying, "I know." What is the basis of that knowledge that you just testified to?
A. The people that I have talked to, the families, the drug treatment counselors.
In public health, we tend to -- we look at populations, and that's why we are never quite really interested -- we are looking at a harmful condition to any group of people. We are trying to sort out and figure out what

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the root cause is, so we can prevent death and disability.
And so in looking at this, all of a sudden there is so many different people, we don't even know where to target it. It is individuals of all classes, all socioeconomic status that are now impacted by wanting opioid drugs.
And so for us, it was where did that come from. So we started to look into it, through data sources, research, reading journal articles, talking to folks, talking to EMS, talking to clients that come through the door, talking to their families, talking to the folks who come to our needle exchange program, and we soon realized that when the supply was starting to dry up, the addiction was still there.
Q. Okay. And so if I can perhaps paraphrase what I think I'm hearing you say, is that the increase in deaths resulted or at least occurred because of patients switching from prescription opioids to illicit opioids?
MS. KEARSE: Objection.
A. I wouldn't say "illicit." I will say from a source they have never had it

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before. So they might have thought it looked just like a little blue pill, or it was somebody's blue pill, but it was also laced with fentanyl or carfentanil.

Q. Well, fentanyl is an illicit substance?

A. Yes. Correct. I'm sorry. I understand what you are saying now, yes.

Q. And roughly, when did Summit County, at least your agency, begin seeing that transition?

A. Probably it was 15 to 16, but particularly in July of 16 is when, I think, we had enough evidence, and it finally hit home, that we had a weekend of many, many overdoses, and it started to really bring it home that, yes, these individuals were addicted and were going to engage in drug-seeking behavior in order to support their habit.

Q. But to be fair, your agency doesn't have patient-level data that will tell you whether any of those patients ever had a legitimate prescription for prescription opioids?

MS. KEARSE: Objection.

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A. That is correct.

Q. And the July 2016 spike in overdose deaths was related to carfentanil?

A. And fentanyl.

Q. So fentanyl derivatives --

A. Correct.

Q. -- analogs. And your agency doesn't have any data at all to suggest that any of those deaths -- any of those patients ever had a prescription for opioid medications?

A. When the assessment is completed, we do ask the question.

Q. Okay. And --

A. So that would be with our subgroup individuals.

Q. The subgroup being --

A. The folks we are providing treatment services for.

Q. Are you suggesting that the counselors knew these patients who had overdosed?

A. No, no, no, no. There are two separate groups. I'm saying that the individuals that we see were seeking treatment. They were saying to us, that, yes, we started

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out with an opiate, I was hurt at work, whatever, got an opiate, took way too much, got addicted.

The group over here, we derived from that information and other data sources that, yes, in fact, it was the same thing occurring here, people were going to the streets to get drugs and ended up dying.

Q. Okay. So let me deal with the information that your agency would be receiving from clients and patients, who are telling you that they got injured, had a legitimate prescription, and transitioned to illegal opioids, either pills or heroin. Is that the type of information that would be maintained in the counselor's assessments?

A. Yes.

Q. Now, going back to the July 2016 deaths, I'm not sure that I quite understand how you are able to conclude that some, none, or all of those involved patients who had previously used prescription opioids?

A. We talked to many of those folks, and knowing the amount of pills that were prescribed and actually even -- we do something

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called quick response teams, where we actually visit the homes of folks that overdose, and we are part of quick response teams in Summit County, so we collect the data.

The reason we feel confident in believing that is there was such a supply. There is no other plausible reason that a bunch of people who could legitimately get a prescription, sometimes even paid for by their health insurance, would go to the streets, unless they couldn't get those pills anymore.

Q. Okay. So it's an educated guess?

MS. KEARSE: Objection.

A. It's more than an educated guess.

Q. So we were talking about six deaths in July of 2016 --

A. Yes.

Q. -- is what you had told me?

A. No. Was it 26 deaths in July?

Q. I thought you said -- I wrote down 26 deaths but --

A. No. I don't remember how many deaths there were.

Q. All right. So it might have been me writing down in my notes wrong, but whatever

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that spike was in July of 2016, your testimony is there was follow-up done by your agency to assess the addiction pattern in some or all of those cases?

A. No, no. We don't look at -- we would never look at 26 people. We look at a much bigger picture in the community.

So those 26 folks, I don't know who they are. We're saying this comes from many sources, and the assumption would be that, yes, in fact, some or maybe all of those folks started with a prescription med. If you apply the 80 percent that everybody tells us, then, yeah, it was a good number of them.

Q. Okay. And how many of those 80 percent, based on the interviews and data you have seen from any source, ever actually had a legitimate prescription for opioids?

A. I don't know that.

Q. If you look at Exhibit 6, in the top chart, it shows an uptick in -- well, I'll ask if you agree with me.

Do you agree with me that top chart shows an increase in drug poisoning deaths beginning in 2011 or 2012?

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A. Yes. I don't know if it is statistical or not significantly, but it is definitely an uptick.

Q. And we don't know, as we sit here, whether those are opioid-related deaths?

MS. KEARSE: Objection.

A. No, we do not.

Q. Do you believe, based on your experience at Summit County Public Health since 2015, that the main driver of that was opioid deaths?

A. Yes.

Q. Would you agree with me that --

A. Or I would agree with you that it was opioid overdoses.

Q. Okay. And would you agree with me that the primary driver for those increases was use of heroin and fentanyl analogs?

MS. KEARSE: Objection.

A. No.

Q. What is that based on?

A. I don't know that.

Q. You don't know, okay. So you don't have -- you can't say one way or the other?

A. Based on this, I have no idea

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what's in those numbers.

Q. All right. Are you aware of any data or analysis from your time as Summit County's -- the health commissioner for Summit County Public Health, as to the cause of any increase in opioid overdoses since 2011 or 2012 is?

MS. KEARSE: Objection.

A. I'm sorry. Could you repeat that, please?

Q. Yeah. I'll try. It was a bad question.

We saw in Exhibit 5 that there has been an increase --

A. Right.

Q. -- in opioid-related deaths.

A. Right.

Q. Do you have an opinion, one way or the other, as to whether those increases in deaths are caused by opioids?

MS. KEARSE: Objection.

A. Yes.

Q. Do you have an opinion, one way or the other, whether those increases in opioid deaths were caused primarily by heroin and

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fentanyl analogs?

A. I don't know that.

MR. NAEEM: I'm surprised I said something that egregiously stupid since we got started, and I'm not excluding the fact that I've said a lot of stupid things since this deposition started.

Q. We have talked about statistics regarding opioid deaths and the data maintained by Summit County Public Health. We have also talked about ADM and the data they may have or have access to regarding opioid overdoses.

A. Yes.

Q. All right. So other than Summit County Public Health, other than ADM, are there any Summit County entities that maintain that type of data, overdose -- overdose data that allows you to drill down to whether it was opioid related or not?

A. Within the whole county?

Q. Yeah.

A. Certainly there are medical records that do, but we don't have access to them. Children's Services, Summit County Children's Services may have some data as related to their

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custody cases, that have children that are placed in custody based on overdose.

Obviously the coroner, not for profits, the 30 subcontractors that Jerry funds, Jerry Craig from the ADM board, Oriana House, Summit County jail, they perhaps would have information that would speak to the -- the sheriffs, well, police officers as well, EMS, some of their run data, which again we don't have access to.

Q. Okay. Have you seen any -- I think you mentioned that the task force, one of the goals that they set for themselves was a reduction in prescription opioids dispensed?

A. Per person.

Q. Per person. How has that changed since 2014, that number?

A. It's going down.

Q. So the conclusion being that the amount of opioids prescribed in Summit County has gone down since 2014?

A. I'm not sure 14, but 15, 16 maybe, 16. Whenever the laws, rules changed.

Q. And I appreciate what you are saying. If we compare 2014 to today,

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regardless of when it started, the number now is lower than it was in 2014?

A. Yes. To my knowledge, yes.

Q. Are you familiar with, and I may not pronounce these correctly, but the Deterra Project?

A. Yes.

Q. Okay. What is that?

A. Deterra is -- there is a local not for profit, Darryl Brake and his group, there is like three people, two or three people. They are a drug prevention organization, and they were able to secure these charcoal-filled bags, and you can dump an opioid in them and seal it up and it disintegrates it. So another way to get drugs out of the community.

So he partnered with, like, Acme pharmacies and a few other pharmacies, that handed out -- when they prescribe an opiate, they then also give them Deterra bags. And then we hand out Deterra bags as well, not that we give out opiates but...

Q. Did you suggest that it's a separate entity that handles that program?

A. Yes. He's a 501(c)(3), yes.

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Q. What was -- the Deterra Project is actually the name of the entity?

A. No, no. Deterra Project is the name of the project. It's with Community Partnership. That's Darryl Brake's group. Darryl Brake, like brake, B-R-A-K-E.

Q. So community project is the name of the --

A. No. That's the name of his 501(c)(3).

Q. And that's what I meant. I'm sorry.

A. Yes. And then he runs the Deterra Project. He was able to secure like 40,000 of those bags for Summit County.

Q. Does Summit County Public Health, other than pass out some of these bags, does it provide any funding to that project?

A. Not to my knowledge.

Q. Do you know whether Mr. Brake received any funding or support from any pharmaceutical companies?

A. I believe he did.

Q. And what is your understanding as to that?

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A. I don't know. I know they came from somewhere. It was not -- he didn't purchase them. I don't remember the name of the company that bought those for him.

Q. Does Mallinckrodt sound familiar?

A. Yeah, that could be it. That may have been it, yes.

Q. And what year did he start that project?

A. 15, 16 maybe.

Q. Has -- strike that.

Have you read the complaint in this case?

A. No.

Q. Do you have any personal knowledge regarding any of the acts or omissions alleged with respect to the pharmaceutical manufacturers?

A. No. We hired attorneys to do that, quite honestly.

Q. Do you have any personal knowledge about any of the allegations against the distributors or pharmacies in these cases?

A. No, I do not.

Q. If I were to go through the list of

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defendants and ask you what products they manufacture, would you know?
A. Maybe, maybe not. Not every single one of them.
Q. Would you know when those companies first began manufacturing those -- each specific product?
A. No. I know some of them came on the market in 96, I believe in the 90s, but that's all I would know. Just very general information.
Q. And again, you have not reviewed any of the warnings or prescribing information or patient information for any of those -- any of the opioid products manufactured by the defendants in these cases?
A. No, I have not.
Q. Have you had any involvement with any of the State of Ohio initiatives to address the opioid crisis?
A. With the attorney general's office?
Q. Any, any of them.
A. Okay. Oh, yes. I have, yes.
Q. You mentioned the attorney general?
A. Yes.

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Q. Have you had any -- and we will get to that in a second, but have you had any involvement with any Ohio Department of Health initiatives to reduce -- or to address the opioid crisis in the State of Ohio?
A. Yes. We receive grant money.
Q. Other than grant money, have you participated in any of the State of Ohio task forces that are addressing the opioid issue?
A. The only one that is not really purely the Ohio Department of Health, but the Association of Health Commissioners drafted a white paper as to what public health could do to help with the opioid situation.
And then I also -- I sat on for like two initial meetings with the health commissioners and individuals that had opioid task forces, and then I assigned it to somebody, but it was really just coming together and sharing ideas.
Those were the only two, but they weren't really Ohio Department of Health, although Ohio Department of Health personnel were there.
Q. When were those?

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A. They were over the last couple of years, maybe a year.
Q. So during your time as health commissioner?
A. Yes.
MS. KEARSE: Are you at a good stopping point? It's about 2:30.
MR. NAEEM: Yeah. We can -- just trying to consolidate --
MS. KEARSE: Another two minutes, break at 2:30?
MR. NAEEM: Might as well do it now. I'm just trying to consolidate what I have left so I can pass it over to these guys.
THE VIDEOGRAPHER: Off the record at 2:31.
(Recess taken.)
THE VIDEOGRAPHER: On the record. 2:50.
Q. Ms. Skoda, I don't think I have much more before I go ahead and let other counsel here ask their questions, but I wanted to clear up one thing.
When, and I'm not sure really whether I asked the question directly, so I'll

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get to it, but when we were talking about heroin and fentanyl and its impact in Summit County, can you put a date on when those substances made their appearance to Summit County, again, contributing to this crisis?
MS. KEARSE: Objection.
A. I was first aware of it in -- end of July -- or end of June, beginning of July of 16, 2016.
Q. And prior to becoming health commissioner, is that something that you would have been aware of, if it had, in fact, occurred or started occurring earlier than summer of 16?
A. I don't know. Maybe, but I don't remember ever hearing about it before then.
- - - - -
(Thereupon, Deposition Exhibit 7, October 26, 2015 Email, Beginning with Bates Label Summit 178390, was marked for purposes of identification.)
- - - - -
Q. Ms. Skoda, handing you what has been marked as Deposition Exhibit 7, can you

please take a look at that.
Have you had an opportunity to review that?
A. Oh, yeah. I know what it is.
Q. This is an email you received in October of 2015; would you agree with me?
A. Yes.
Q. And what's the subject of the email?
A. It is Increase in the Fentanyl Drug Confiscations and Fentanyl-Related Overdose Drug Fatalities.
Q. And who is this email from?
A. These alerts started in about 2003. They come from the State of Ohio or CDC wanting to get information out. They are sent to probably, oh, 25, 30 people in our organization, maybe even more than that, 35, at different levels of reporting.
So I may have well received this, yet it didn't apply to me, so I wouldn't have done anything with it.
Q. Okay. But you did forward it --
A. Yes.
Q. -- from one of your email addresses

to another one of your email addresses?
A. I may have done that. Who did it go to? Oh, my home address, just to make sure I had it, yes.
Q. And the subject of this email is increases in fentanyl -- part of it is fentanyl-related overdose facilities; do you see that?
A. Correct.
Q. So by your testimony about July 2016, you weren't saying that fentanyl hadn't caused overdoses in Ohio or Summit County prior to that, you were just saying that's when you became aware of that?
MS. KEARSE: Objection.
A. Yes.
MR. NAEEM: All right. I don't have anything else. So it was two minutes, Anne.
MS. KEARSE: Murphy's law, right.
MR. NAEEM: So I'm going to go ahead and turn it over to Mr. Salimbene.
THE VIDEOGRAPHER: Off the record, 2:54.
(Pause.)

THE VIDEOGRAPHER: On the record, 2:55.
EXAMINATION OF DONNA SKODA
BY MR. LAVELLE:
Q. My name is John Lavelle. I'm an attorney with Morgan Lewis, and I'm representing Rite Aid of Maryland. So I'm going to ask you some more questions.
Is it okay if I call you Commissioner?
A. You can call me Donna.
Q. Okay. Whatever you are most comfortable with.
I wanted to start with the issue of my client being sued in this case. Are you aware that Rite Aid is a defendant in this case?
A. Yes.
Q. Do you know when they were added as a defendant?
A. No.
Q. Do you know why they were added as a defendant?
A. No.
Q. Do you know whether they were sued

at the same time as the other defendants?
A. I don't know that.
Q. I want to show you an exhibit.
MR. LAVELLE: Let's mark this, please.
- - - - -
(Thereupon, Deposition Exhibit 8, LinkedIn Profile of Donna Skoda, was marked for purposes of identification.)
- - - - -
Q. Donna, we've marked as Exhibit 8 a LinkedIn profile that, I believe, I found for you.
A. Okay.
Q. Do you recognize that?
A. Actually, no. I mean, I recognize it, but we only put that up because we needed to have it for a grant we applied for. I don't do much with it.
Q. Okay. Well, first of all, do you have a LinkedIn profile?
A. Yes.
Q. Does what we have marked as Exhibit 8 look to you like your LinkedIn profile?

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A. Maybe. I mean, that probably sounds totally crazy, but I don't really ever go here.
Q. Did you have any involvement in putting up the LinkedIn profile --
A. When we needed it for a grant, we did, about, oh, a while ago.
Q. Well, I'll just give you -- I think you got the direction earlier from counsel, it's important that you wait until I finish --
A. Okay. I'm sorry. Yeah.
Q. -- the question -- that you wait until I finish asking a question before you answer it, otherwise --
A. Okay.
Q. -- we are talking over one another.
A. Okay.
MS. KEARSE: Counsel didn't give that advice, but go ahead.
Q. Okay. All right. Well, I'm going to ask that you try and -- and I'll try and work on finishing my questions before you give an answer.
Okay. So specifically with respect to this document, the reason I put it in front

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of you, I just wanted to have collected in one place what I thought was your professional background here. Can you tell me whether this is an accurate description of your professional background?
A. It's very -- it's not updated, and it's very -- it's hieroglyphic, at best.
Q. Okay. Why don't you tell me, under experience, what is incorrect, if anything that's listed there?
A. If you start -- do you want to go up from the bottom? But if you start at education, where I think is where I started the last time, I originally went to Kent State University and received that degree in social work/corrections, and then I went to the University of Akron to complete the undergraduate coursework that was needed, and then I went to Case Western Reserve University.
Q. So Kent State is not listed here --
A. Correct.
Q. -- in your LinkedIn profile?
But other than that, the description of your education is correct?
A. Yes.

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Q. And you received a Master's from Case Western in nutrition and public health in 1990; is that correct?
A. Correct.
Q. Okay. Now let's turn to the description of your experience.
A. When -- there is some things missing. I worked at MetroHealth Medical as a dietician in there as well, doing some home visiting for children with special healthcare needs.
Q. What time period was that?
A. It would have been 80 -- I'm sorry, I had to be a dietician. 91 to maybe 93 or 4.
Q. Did that overlap at all with any of the other jobs that are --
A. Cuyahoga County Board of Health, because for a while I was part time at both. I was part time at MetroHealth Medical and part time at the board of health.
Q. How long a period did you overlap at both of those?
A. A couple years maybe, year and a half, two years.
Q. So this profile lists you as

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starting at Cuyahoga County Board of Health as a supervisor in June of 1993; is that correct?
A. Yes. It might -- it was supervisor, yes.
Q. And it shows that you were there until July of 2001; is that correct?
A. Correct.
Q. And how about the next entry going up the chart?
A. That's what I was debating earlier. I'm not sure it was called policy or planning, or what the actual title was, director. And then I became a deputy health commissioner, and then I became the health commissioner.
Q. So your LinkedIn profile says that you were with Summit County Public Health in the position of director of policy and planning from June of 2001 to August 2011. Did I read that correctly?
A. Yes.
Q. And is that accurate?
A. There was a couple of positions in there, so I really don't remember.
Q. So this period of June 2001 to August 2011, you had some other positions

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as well --
A. Yes.
Q. -- that are not reflected on this?
A. Yes. Other duties, other positions.
Q. The position of deputy health commission for planning, did you assume that in August of 2011?
A. Yes.
Q. And you held that position through June of 2015; is that correct?
A. Yes. I actually thought it was August of 2012, but it might have been 2011.
Q. What's your best recollection today?
A. 11, we'll say 11.
Q. Okay. And this LinkedIn profile says that you became the health commissioner in July of 2015. Is that accurate?
A. Yes.
Q. And you continue to hold that position today?
A. Yes.
Q. In your role as health commissioner, do you have any supervisory

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responsibility for pharmacies?
A. No.
Q. Have you ever, in any of your job positions that we looked at here, had any responsibility for supervising pharmacies?
A. No.
Q. You are not a physician; is that correct?
A. Correct.
Q. You are not a nurse?
A. Correct.
Q. You have never gone to medical school?
A. No.
Q. You're not licensed by the State of Ohio to write prescriptions, are you?
A. Correct.
Q. And you would, therefore, not be licensed to write a prescription for an opioid; is that correct?
A. Correct.
Q. Do you have any interactions currently, as commissioner, with retail pharmacies?
A. The only one I can say we have ever

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really interacted with was the Acme pharmacies, and that's been quite a while. His name was Joe Lahovich.
Q. I'm sorry. Was that an acronym that you gave earlier, Acme?
A. Acme. It's a local grocery chain.
Q. Acme, the grocery store.
A. Yeah.
Q. A-C-M-E?
A. Yes. It's a local grocery store.
They were working with us on some disaster-preparedness events and some activities, and Joe was agreeing to be our Strategic National Stockpile, allowing us to store -- they have large warehouses. They were going to allow us to store some of the pharmaceuticals we needed for preparedness at their warehouse.
So that was really my -- other than personal interaction with a pharmacist for my own prescriptions, that would be it.
Q. Any of that interaction you had with the Acme pharmacist, did that have anything to do with opioids?
A. No.

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Q. Have you ever had any professional contact with Rite Aid?
A. No.
Q. How about with Walgreens?
A. Professional contact?
Q. Yes --
A. No.
Q. -- in any of the positions that we have looked at as health commissioner or in any other position you have held for Summit or Cuyahoga Counties?
A. No.
Q. How about with respect to CVS, you have had any professional contact with any of them --
A. No.
Q. -- with CVS?
How about with Walmart?
A. No.
Q. Any other retail pharmacy that we haven't already mentioned that you have had professional contact with?
A. No.
Q. In your role as commissioner, do you have any responsibility for supervising

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distributors of prescription drugs?
A. No.
Q. Do you have any interactions with drug distributors?
A. No.
Q. Do you know who supplies pharmaceutical products to Rite Aid?
A. No.
Q. Do you know who supplies them to Walgreens?
A. No.
Q. Do you know who supplies them to CVS?
A. No.
Q. To Walmart?
A. No.
Q. Would you agree that there are some patients for whom opioids are an appropriate treatment?
MS. KEARSE: Objection.
A. Yes.
Q. How would you define that group?
A. The original intent for end of life, hospice care, surgery, under a very controlled situation.

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Q. And who gave you the information on which you base that understanding?
A. I think the literature that I have read, and understanding that -- knowing that when you don't have constraints around those drugs, that they can be misused and used and put out into the community where there is just too many of them.
So I have, over the last three years, developed an opinion and a belief and knowledge that it needs to be in a very controlled substance when those -- or situation when those drugs are used.
Q. We already covered that you yourself can't write prescription --
A. Correct.
Q. -- for opioids, right?
Do you know whether your belief is consistent with what federal law provides?
A. I do not know.
Q. Do you know whether your belief is consistent with what Ohio law provides?
A. I do not know.
Q. Would you agree with me that doctors are ultimately responsibile for

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determining whether patients receive prescription drugs?
MS. KEARSE: Objection.
A. I'm sorry. Could you ask that again?
Q. Sure. Would you agree with me that doctors are responsible for determining whether patients get prescription drugs?
A. Physicians and anybody who has prescriptive powers can determine whether or not somebody gets a drug.
Q. And I believe you discussed that earlier today, but that would be physicians, nurses who have the ability to write prescriptions? Is there anybody --
A. Physician assistants.
Q. Physician assistants.
A. Psychiatrists, anyone who has the ability to -- who is licensed in Ohio to write prescriptions.
Q. Right. Are you familiar with the Controlled Substances Act?
A. Yes.
Q. How did you become familiar with the Controlled Substances Act?

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A. When I was a parole officer, individuals used to be arrested when they would -- if they were forging prescriptions or trying to get drugs illegally, they would be -- I mean, DEA or whomever was doing the investigation would cite those rules and regulations.
Q. Do you know how prescription opioids are regulated under the Controlled Substances Act?
A. Not specifically. I just know they are controlled.
Q. Are you aware that there are different levels of -- different schedules --
A. Yes.
Q. -- within the Controlled Substances Act?
A. Yes.
Q. Okay. Again, I'll ask you to wait until I finish a question before you answer it.
So let me just ask the question again. Are you aware that there are different schedules within the Controlled Substances Act?
A. Yes.
Q. And that there are different levels

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of control on particular categories of drugs based on what schedule they fall within?
A. Yes.
Q. Do you know what schedule prescription opioids fall into?
A. No, I do not.
Q. Are you familiar with the duties of distributors under the Controlled Substances Act?
A. No, I am not.
Q. Are you familiar with the Ohio Board of Pharmacy?
A. Yes.
Q. How are you familiar with the Ohio Board of Pharmacy?
A. We have a terminal dispensing license through the Ohio Pharmacy Board that we have to renew in order for our medical director to be able to provide free STD drugs to our patients.
Q. So your department actually dispenses drugs; is that correct?
A. STD drugs would be it.
Q. And that's through a grant of authority from the Ohio Board of Pharmacy; is

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that correct?
A. Correct.
Q. Do you yourself interact with the Ohio Board of Pharmacy in a professional capacity?
A. No, only in that they have attended a few meetings I have been at, but that would be it.
Q. I think you have testified earlier about something called OARRS?
A. Yes.
Q. I think that's an acronym for the Ohio Automated Rx Reporting System; is that correct?
A. Yes.
Q. How are you familiar with OARRS?
A. OARRS data has been presented at the Opiate Task Force and a few other presentations I have been at that talks about the number of pills that have been prescribed per person in Ohio.
Q. What is your understanding of what OARRS is?
A. Oh, OARRS is a program for which -- what happens is you -- when somebody gets an

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opiate prescription filled, you put their name and everything in there, and then that allows physicians to monitor and see if they are doctor shopping, or allows pharmacists to look in there to see if, in fact, people are going to one or more places before they fill a prescription, or actually it is used to keep track of where these opiates are going and where they are being prescribed.
Q. Does OARRS provide data to people in the community?
A. Not directly, no. Only if you're an OARRS user, you have to have a reason to have OARRS licensure -- you have to be -- your patients are in OARRS, and you have been able to get access to your patients in there, and that's it.
Q. Are you aware that OARRS has a public website?
A. Yes.
Q. Are you aware that OARRS issues reports to the general public?
A. Yes. Aggregate, yes, yes.
Q. Have you ever seen any of those reports?

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A. Maybe just once. Rich Marountas, in our office, would pull those off and look at them, if he was interested in looking at them.
Q. Why would Rich look at those records?
A. He's our epidemiologist, and he may just want to track and look and see what is happening.
Q. Now, you described earlier today that there was something that happened in July of -- or late June or July of 2016 that made you realize that there was an issue.
MS. KEARSE: Objection.
Q. Do you remember that testimony earlier today?
A. Yes.
Q. What specifically happened, was there a specific incident that occurred then?
A. It was the weekend that there were many, many overdoses in Summit County, that sent individuals to the ER, and I think as a result of that, when we realized that it was illegal -- most of it was -- the overdoses were caused by fentanyl and carfentanil.
But when we realized it was

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individuals that were using this as a substitute for either a prescription medication or somehow were hooked on opioids were using this, were going to the streets when the supply was drying up, and I think what happened then, drug manufacturers -- not drug -- I meant not you, not drug manufactures, but illegal drug manufactures brought carfentanil and fentanyl, whether it came from China or Mexico or wherever, brought the drugs into Summit County, because the supply of medication -- or prescription opioids was drying up.

Q. So how many incidents were there that occurred that weekend?

A. I can't remember exactly, but it was a good number. I mean, I want to say we had an unbelievable number of deaths -- or overdoses that weekend.

Q. I understand you may not be able to give a precise number, but if you can give an approximation, that would be useful.

MS. KEARSE: Objection.

A. I want to say like 20 or 35, somewhere in there, like.

Q. And that to 20 to 35 deaths

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involved --

A. No. I believe it was just the overdoses peaked, and then we had deaths.

Q. Do you know how many deaths there were among that group?

A. No, I don't.

Q. And how many of those 20 to 35 involved fentanyl or carfentanil?

A. Again, I'm sorry, I just don't know.

Q. How many of them were people who had previously been prescribed opioids?

A. I don't know that either.

Q. Do you know whether any of them had been?

A. No.

Q. So really what struck you in July of 2016 was that there was a problem with fentanyl or carfentanil; is that right?

A. There were a number of individuals who had drug-seeking behaviors that caused them to use, thinking -- my personal recollection is that I remember talking to one gentleman who had overdosed and said he thought he was buying an oxy in the street, like he always did, to

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support a habit, but he didn't, he got a carfentanil, because it looked the same, and he thought that's what it was.

So to some extent we believe that there was a lot of that behavior when the supply dried up, and there was not as many being dispensed. As the opiate per capita was going down, the street use was going up.

Q. So in that particular incident that you referred to, that anecdote, that was an individual who thought he was buying one drug illegally and was actually buying another drug illegally; is that correct?

A. Yes.

Q. Do you know whether that individual had ever been prescribed opioids?

A. I do not.

Q. I believe you said that, "The supply was drying up." Can you explain what you mean by that?

A. What was happening was there was recommendations coming down that no longer should we be prescribing -- or anybody in the medical community be prescribing as many opioids for conditions for which it wasn't

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originally intended.

So if it wasn't end of life, it wasn't cancer treatment, there were other ways to address chronic pain, and we should stop giving -- I say "we," collectively the medical community should stop out -- stop giving opioids for headaches or backaches.

And so I think when that started to happen and some of the pill mills were shut down and some of the prescribers, I think, were starting to realize that maybe we shouldn't do this, then people started to get other sources, because when you're addicted, you're addicted. You will go get the drug, even if it is a really bad decision for your life.

Q. Okay. So I understand you have a hypothesis here, but do you have any facts, as we sit here, to suggest that any of those 20 to 35 people had actually ever been prescribed opioids?

MS. KEARSE: Objection.

A. I would say yes.

Q. Okay. And what are those facts?

A. That the data sources that we reviewed, and when we talked to the patients

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about treatment, about 80 percent of all individuals that now use street drugs or who have turned to the other ways to get their medications, began with an opiate or an opioid prescription from a physician.
Q. Those are statistics that are general?
A. I'm sorry?
Q. Those are general statistics, correct?
A. Yes.
Q. But those are not statistics with respect to this 20 to 35 incidents?
A. Correct.
Q. You do not know as we are sitting here today, on August 14, 2018, what caused any of those people to become addicted to opioids, do you?
A. Correct.
Q. When do you understand that the supply dried up, as you put it?
A. I think we knew that the dispensing per person was going down, and I do believe with police activity and, you know -- because it takes a multifaceted approach to try to get

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street drugs off the street, to get the supply down. There was a lot of push to start, you know, getting rid of opioids out of your cupboards, you know, don't let it be in -- you know, get rid of it, get rid of all that stuff, start to ask questions.
So I would say that probably before that big weekend of a lot of drug use, we started to realize that, yes, the supply was drying up.
Q. And as best you understand it, to what do you attribute that drying up of the supply?
A. I think the rules changed for dispensing. There was enough education out there to tell people that we needed to -- or physicians, or whomever, that maybe they should rethink prescribing as many opioids as they were.
Q. What rule specifically are you referring to there?
A. I believe the state law change that had said that you couldn't dispense as many.
Q. And when did that law change?
A. I'm not exactly sure. Because

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there has been another revision to that law, like no more than seven days now, and all that stuff.
Q. When did that occur?
A. Just recently, maybe four or five months ago.
Q. Anything else, other than this law change, whenever that occurred, that you can identify today as a cause for the supply drying up, as you put it?
A. No.
Q. Do you think police work had anything to do with it?
A. Perhaps. I was thinking there was some, but, you know, the problem started out, you know, there has always been DEA and drug enforcement units that are local, and there has always been individuals that have always tried to curb the availability of drugs in the street, from marijuana to anything, and those agents have always worked.
I don't know if they knew what they were going after. I think in general, I mean, it's so diverse and it's across so many socioeconomic classes, I don't know if they

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knew who they were trying to target to reduce the amount of drugs, other than that illegal trafficker.
Q. When, as you understand it, did the supply dry up?
A. I think beginning maybe four -- maybe a couple three months before that event, four months, to my knowledge.
Q. So early 2016?
A. Yes.
Q. Is supply still dried up today?
MS. KEARSE: Objection.
A. I don't believe so.
Q. It's gotten worse since then?
A. No. I think the dispensing may be down. I don't know.
What makes this so difficult, from a public health perspective, is that, you know, we look at a lot of data sets and we look at a lot of information, we talk to a lot of people, we try to find out, we review the refereed literature to see what we should by doing or what really seems to work, and when we do that, this has been probably the most difficult problem to get our hands around, because there

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is a whole group of people that, you know, that have insurance, who can legitimately maintain an addiction for a long time without ever coming to the surface, and that is the group, to me, that is probably going to be the most difficult for public health to get their hands around.

There is another, you know -- there is a group of people that, yes, sure, started out smoking marijuana, ended up, but that group that cuts across all SES, that cuts across white, black, whoever you are, we don't know who those people are to target resources to try to stop this and to get other ways for pain management and whatever it takes to get people off of pills to maintain their pain. And that's what's made it so tough for us.

Q. Commissioner, do you remember what my question was?

A. No. I'm sorry.

MR. LAVELLE: Can we read back the question, please, and strike that answer as nonresponsive.

MS. KEARSE: Objection. Just read the question back. She answered your question.

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THE NOTARY: Question: "It's gotten worse since then?"

MR. LAVELLE: And the question before that?

MS. KEARSE: Your question was --

THE NOTARY: Question: Is supply still dried up today?"

"Objection."

Answer: "I don't believe so.

"Question: "It's gotten worse since then?"

Q. So can you answer that question, it's got even worse since then?

A. Yes.

Q. How has it gotten worse since 2016?

MS. KEARSE: I'll make an objection. She did answer your question.

A. I tried to answer that by saying that I don't -- I think it's gotten worse because we really can't get our hands around knowing exactly where the problem is and where it lies in regards to the number of prescriptions that are out there.

Q. Commissioner, when did the OARRS database open?

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A. I believe it was 2015. It was mandated in 2015.

MR. LAVELLE: Let's mark this as the next exhibit, please.

- - - - -

(Thereupon, Deposition Exhibit 9, Publication of the Ohio State Board of Pharmacy About the Ohio Automated Rx Reporting System, was marked for purposes of identification.)

- - - - -

Q. Ms. Skoda, I have put in front of you a document that is the publication of the Ohio State Board of Pharmacy, about the Ohio Automated Rx Reporting System, or OARRS --

A. Correct.

Q. -- it is a House Bill 93 report dated November 21, 2011, and I'll represent to you that we found this on the public section of the OARRS website.

A. Right.

Q. Have you ever seen this before?

A. No.

Q. Are you familiar with House Bill 93?

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A. No.

Q. Let's take a look at page 3 of this.

MS. KEARSE: I'll object. She said she's not familiar with this document, never seen it.

MR. LAVELLE: I understand.

Q. Under Background, would you mind reading the first two sentences?

MS. KEARSE: Again, she has never seen this document before. So if you're going to ask her to see what it says on there, I don't think it is appropriate to ask her questions about it.

Q. You can go ahead and read it.

A. "In 2004, House Bill 377 was passed by both the Ohio House of Representatives and the Ohio Senate. It was signed by governor and became law in May of 2005."

Q. And then the next sentence?

A. "It allowed the board of pharmacy to develop and operate a dangerous drug database."

Q. Does looking at this help refresh your recollection that the OARRS database

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actually started much earlier than 2015?
MS. KEARSE: Objection.
A. No.
Q. You weren't aware of that until I told that you today?
A. Correct. I have never seen this. I didn't know this existed. I think -- what I think, I believe I said, was in 2015, it was mandated. I don't know when it was developed. I think 2015 is when they told physicians, "You have to report to this." I don't know when this was originally developed.
Q. As best you understand, as you can sit here today and tell us, do you know when the OARRS database opened up?
A. No.
Q. Was it prior to 2015?
MS. KEARSE: Objection.
A. According to this document that I've just received, it was.
Q. All right. Let's turn to the next page, please.
MS. KEARSE: Again, the document speaks for itself. I'm going to object to reading the document.

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Q. There is a paragraph that starts at the top of that page, starting with, "In May 2011"?
A. Right.
MS. KEARSE: What page are you on?
MR. LAVELLE: Page 4.
Q. Would you mind reading the first three sentences there?
A. "In May 2011, House Bill 93 became effective. This law made sweeping changes to address the epidemic of prescription drug abuse and overdose deaths in Ohio. The objective was to address those individuals who were masquerading as legitimate medical care providers but, in reality, were drug traffickers."
MS. KEARSE: And I'm going to object to her just reading statements without a pending question, when you're having her read the document. The document speaks for itself.
If you got a question about something, just ask her a question and she can review the document. I don't think it is appropriate for her to be reading the document.
MR. LAVELLE: Okay. Your objection is on the record.

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Q. Commissioner, are you familiar with HB, or House Bill 93?
A. No.
Q. You have never heard of it before?
A. No.
Q. Are you aware of the problem of individuals masquerading as legitimate medical care providers but who in reality were drug traffickers?
MS. KEARSE: Objection.
A. No. I'm not sure what that sentence means.
Q. You talked about pill mills earlier?
A. If they are referring to that, yes.
Q. Do you know whether there were changes made in the law in Ohio in May of 2011 in order to address prescription drug abuse?
A. No, I do not.
MR. LAVELLE: Let's mark this as the next exhibit, please.
- - - - -
(Thereupon, Deposition Exhibit 10, OARRS 2017 Annual Report, was marked for purposes of identification.)
- - - - -

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Q. Commissioner, we put in front of you the 2017 annual report of OARRS as published on their website.
A. Yes.
Q. Have you ever seen this before?
A. No.
Q. Have you ever looked at any annual reports of the OARRS system?
A. I don't believe so.
Q. Can you turn to page 3, please, of this document. It has State of Ohio Board of Pharmacy at the top. It's a letter in the form -- it's in the form of a letter from Steven Schierholt.
A. Okay.
Q. Do you know who Steven Schierholt is?
A. No, I don't.
MS. KEARSE: Again, I'll make an objection. She just testified she has never seen this document. To the extent you are going to have her read parts of this document, I think is inappropriate. You can ask her

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questions about it.
Q. In this letter, Mr. Schierholt says to Governor Kasich and members are the Ohio General Assembly, I'm going to read the first bullet point here, that, "The total doses of opioids dispensed to Ohio patients decreased by 225 million doses, or 28.4 percent, from 2012 to 2017." Do you see that bullet point I just read?
A. Yes.
Q. Were you aware of that prior to my reading that to you?
MS. KEARSE: Objection.
A. I knew that they were going down, but I didn't know the actual facts, how much they were going down. And that's all across Ohio. I'm not sure that's Summit County, correct? So I wouldn't have looked at anything that wasn't --
Q. I'll try and show you something in a little bit that --
A. Okay.
Q. -- will focus specifically on Summit County, but let's just focus on this bullet point.

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Were you aware, prior to my reading that bullet point to you, that the total doses of opioids dispensed to Ohio patients, during the period 2012 to 2017, had decreased by 28.4 percent?
MS. KEARSE: Objection.
A. No, I do not.
Q. Does that surprise you?
A. No.
Q. Do you have an understanding, as you sit here, why that occurred?
A. No. I would assume they stopped dispensing as much.
Q. The fourth bullet point here in Mr. Schierholt's letter to the governor and the members of the general assembly states, "The number of individuals engaged in doctor shopping behavior decreased from 2,205 in 2011 to 273, or 88 percent, in 2017"; do you see that?
A. Yes.
MS. KEARSE: Again note an objection. The document speaks for itself.
Q. Were you aware of that prior to my reading that to you?

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A. No.
Q. Do you know what doctor shopping is?
A. Yes.
Q. Can you give us your understanding of what doctor shopping is?
A. My understanding is that it is an individual that would go to multiple providers, trying to secure an opiate prescription, opioid prescription.
Q. Why would someone go to multiple providers?
A. So you can get more of them.
Q. So it's a bad thing; is that right?
A. Yes.
Q. Was it your understanding, prior to my reading that bullet point to you, that doctor shopping behavior had decreased in Ohio?
A. No, but it would make logical sense. Once you started monitoring it, you would be able to identify those individuals.
Q. Your understanding is that this OARRS database has helped reduce doctor shopping?
MS. KEARSE: Objection.

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A. Yes.
Q. All right. I want to take you to the page that's captioned Section 1. It says Opioids Dispensed to Ohio Patients.
Have you ever seen these statistics before? These are details about the decrease of 28.4 percent in total doses of opioids in Ohio.
A. No, I have not seen them for Ohio. Summit County, yes, but not Ohio.
Q. Were they decreasing for Summit County during this same period of time?
A. Yes. I don't know where the decrease began, but I have been told they go down.
Q. What is your understanding of why they decreased in Summit County during that time period?
A. Dispensing practices.
Q. Can you be more specific?
A. Any provider that can dispense medications, it was my understanding, they were no longer prescribing as much.
Q. And when did that start in Summit County?

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A. I don't know.
Q. Let's turn to the next page. You referred earlier in your testimony to MED?
A. Yeah.
Q. Do you remember using that term?
A. Yes, morphine equivalent dose.
Q. There is a definition of morphine equivalent dose here in this document. Would you mind reading it for us into the record?
MS. KEARSE: Objection.
A. The very first paragraph?
Q. Yes.
A. Okay. "A morphine equivalent dose, MED, is the total amount of the opioid medications converted to a common unit of milligrams of morphine that a patient currently has access to based on the information reported by prescribers and pharmacies to OARRS."
Q. Can you read the next two --
A. "Morphine is widely regarded as the standard of treatment of moderate to severe pain and is commonly used as a reference point. As MED increases, the likelihood of an adverse event increases, therefore identifying at-risk patients is a crucial first step towards

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improving patients safety."
Q. Do you agree or disagree with this definition of MED, or morphine equivalent dose?
A. It's scientific. I have no basis to question it. It's a conversion that's used to see how much you're getting of morphine.
Q. But has this -- has OARRS described accurately, in your view, what morphine equivalent dose is?
MS. KEARSE: Objection. Asked and answered.
A. Yes.
Q. Can you read for us what the average daily MED per prescription was dispensed to Ohio patients per year in the year 2010?
A. Average in Ohio, it would have been 64.37.
Q. I believe that's the average quantity per --
A. Oh, I'm sorry. The MED would be 53.35.
Q. And by 2017, what was that number?
A. 43.23.
Q. Do you agree with me that's a

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decrease?
A. Yes.
Q. Would you agree with me that that is another measure by which we can see that the prescriptions of opioids to Ohio patients went down during the time period 2010 to 2017?
A. I think it's an average, yes.
Q. Now, I think you described earlier that you wanted to see some specific Summit County statistics.
MS. KEARSE: Objection.
Q. Do you remember that?
A. Yes. I just said I hadn't seen them so...
Q. So have you ever looked on the OARRS website to see if they make that available to the members of the general public?
A. I don't believe so.
Q. You weren't curious, as commissioner of public health, to see whether OARRS actually makes that data available?
MS. KEARSE: Objection.
A. No.
MR. LAVELLE: Let's mark this as the next exhibit.

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- - - - -
(Thereupon, Deposition Exhibit 11, Printout Generated From OARRS Public Website, was marked for purposes of identification.)
- - - - -
Q. Commissioner, I have put in front of you what we have marked as Exhibit 11, a printout we generated from the OARRS public website, which compares Summit County to the county average for the different statistical measures that are covered there.
Have you ever seen this type of data from OARRS before?
A. No.
Q. And you were not aware, prior to my showing this to you, you could get this information from the public database, were you?
MS. KEARSE: Objection.
A. Correct.
Q. Would you look with me at the second page of this document, the Average Daily MED Per Ohio Patient By County and Quarter, do you see that caption at the top of the chart that is there, Average Daily MED Per Ohio

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Patient By County and Quarter?
A. Yes.
Q. Are you familiar with what that means?
A. It would be the amount of MED given to a patient by the quarter -- by a quarter, a three-month period of time.
Q. And in this chart, there are two lines. There is a line which, according to the legend on the bottom, is blue --
A. Right.
Q. -- which is Summit, and then there is a line which is yellow, which is county average. Do you agree with me?
A. Yes.
Q. And from left to right, it progresses in time. So for 2010, quarter 1, to the far left, all the way to 2017, on the far right.
A. Okay.
Q. Would you agree with me that this chart shows that the average daily MED per Ohio patient by county and quarter is going down for Summit over the period of time that's covered here?

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A. Yes, just looking at it, but it kind of looks like it levels off at the end there. So I'm not sure what's going on.
Q. In fact, it is above the county average in the early years, but then it comes to be --
A. Correct.
Q. -- about the same as the county average?
A. Correct.
Q. Looking at the next chart, it's captioned Average Day MED Per Capita to Ohio Patients by County and Quarter. Is that a measure you were familiar with?
A. No.
Q. You never heard of that before?
A. No.
Q. Do you have an understanding of how that would be different than Ohio patient?
A. This is a per capita number?
Q. Yes.
A. Okay. Divided, okay, over time, yeah.
Q. So what do you understand "per capita" to mean?

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A. Per every individual.
Q. And you would agree with me that, again, this is a chart that shows a line for Summit, which is in blue; do you agree with me, Commissioner?
A. Yes. Oh, yeah.
Q. And the line underneath it is the county average?
A. Yes.
Q. And as on the previous one, this progresses through time. So the far left is the earliest time, 2010 quarter 1, the far right is 2017, the most recent that's covered in the chart; do you agree?
A. Correct.
Q. And this chart shows that, again, Summit is above the county average at the beginning of the chart in 2010 and it has descended down below the county average by 2017; is that right?
A. Yes.
Q. So that's good news; isn't it?
MS. KEARSE: Objection.
A. Yes. I'm hopeful.
Q. And the number has gone down quite

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a bit, it has gone down from close to 3 MEDs, in the early years, down to 1.7 in 2017; is that right?
A. Yes.
Q. Assuming that these numbers are correct, would you have an understanding of why that occurred during that time period?
A. Other than prescribing habits, no.
Q. I think you described earlier in your testimony today something called divergent; do you remember being asked about?
A. Diversion, yes.
Q. Yes. What do you understand diversion to be?
A. Diversion, in the pharmaceutical world, to me is when you have a prescription that is written, and it's taken by somebody else, other than for who it is intended.
Q. Have you been able to find any statistics that helped quantify how much diversion has occurred in Summit County?
A. No.
Q. Are you aware of any attempts to measure that?
A. No.

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Q. Have you ever asked anybody for statistics on diversion?
A. No.
Q. I think you described earlier use of illegal opioids, such as heroin. Are there statistics available in Summit County for heroin use?
A. There are estimates of use.
Q. And who provides those estimates?
A. Ohio Department of Health.
Q. I'm sorry?
A. Ohio Department of Health and/or the ADM board.
Q. So that is not done by your department?
A. No.
Q. Do you have access to those statistics?
A. Yes. Aggregate, yes.
Q. Do you have an understanding, as we sit here today, whether heroin use has been increasing, decreasing, or remains the same in Summit County over the past five years?
A. It has been increasing.
Q. Has it increased over the past ten

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years?
A. I am not sure.
Q. How about the use of illegal fentanyl, is that something that is tracked in any type of statistics that you are aware of?
A. No. Only in the work of the coroner, where she does the tox reports, and I think there is probably some police data somewhere that talks about the availability of fentanyl, but I don't know about the --
Q. You're not familiar with that?
A. No, I'm not familiar.
Q. We talked about fentanyl, we talked about heroin. Are there any other illegal opioids that you are aware of for which there is any effort going on to try to track statistically usage in Summit County?
A. When you say "opioids," you mean all of the opioids?
Q. Yes.
A. No.
Q. Have you ever asked anybody to try to track that information?
A. No.
Q. Are you familiar with counterfeit

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opioids, have you ever heard of those?
A. No.
Q. I think you described an incident earlier.
A. Okay. That's what I thought you were referring to. Yes. I didn't know that's what they were called.
Q. Can we agree that that would be an instance of a --
A. Yes.
Q. -- counterfeit opioid, where someone thinks they are buying illegally one opioid, it turns out they are buying a different opioid?
A. Yes.
MS. KEARSE: Objection.
Q. Do you know whether there are any statistics available to measure how prevalent that is in Summit County, that is counterfeit opioids?
A. No, I do not know.
Q. Do you know whether that has increased, decreased, or remained the same over time?
A. I do not know.

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Q. Do you know whether deaths from prescription opioids have gone up, gone down, or remained the same over time?
A. I'm sorry? Could you ask that again, please?
Q. Yes. Could you tell me whether deaths attributable to prescription opioids have gone up, gone down, or remained the same in Summit County over time?
A. I cannot, just to one cause, one opioid, no.
Q. How about generally to the category of prescription opioids?
A. Opioids in general, the overdoses and deaths have gone up. Whether or not it's a prescription, what prescription it was, I don't know.
Q. And you can't distinguish between prescription and nonprescription, that is illegal --
A. Well, the coroner can, but we don't have access to that.
Q. Are you aware of any statistics that are available, as we are sitting here today, that measure whether or not prescription

opioid deaths have gone up, gone down, or remained the same in Summit County?
A. My understanding is they have gone up.
Q. So what statistics are you aware of that mention that?
A. From any of the sources, like CDC or the Ohio Department of Health, that says opioid-related deaths are up and overdoses.
Q. Are those specifically prescription opioids or just opioids?
A. I do not know that.
Q. Okay. So let me go back to the question I asked earlier.
A. I'm sorry. Yes.
Q. And I apologize if I'm being confusing here. I'm trying to be clear.
Are you aware of any statistics that measure whether deaths attributable to prescription opioids have gone up, gone down, or remained the same in Summit County?
MS. KEARSE: Objection.
A. No.
Q. Do you know of anyone who has attempted to measure that statistically?

A. No.
Q. You talked earlier about pill mills. Do you have any understanding, as we sit here, about how significant pill mills were contributing to the opioid problem?
MS. KEARSE: Objection.
A. No, I do not.
Q. Is there any measurement that you are aware of, any statistics that help us define how many opioids came from these pill mills?
A. No, I do not.
Q. Do you know who distributed opioids to the pill mills?
A. No, I do not.
Q. Do you know whether pill mills were distributed opioids from Rite Aid of Maryland?
MS. KEARSE: Objection.
A. I don't know that.
Q. How about CVS?
A. I don't know that.
Q. Walgreens?
A. I don't know that.
Q. Walmart?
A. I don't know that.

Q. Would it surprise you to learn that Rite Aid of Maryland only distributes medications to Rite Aid pharmacies?
MS. KEARSE: Objection.
A. No. That makes sense to me.
Q. Would you agree with me that if that's true, that means Rite Aid is not responsible for opioids that came from pill mills?
MS. KEARSE: Objection.
A. I'm sorry. Again?
Q. Would you agree with me, I told you it was true that Rite Aid of Maryland only distributes to Rite Aid pharmacies, that that means that Rite Aid of Maryland is not responsible for opioids that came from pill mills?
MS. KEARSE: Objection.
A. I can't say that.
Q. Are you familiar with hydrocodone products?
A. Like Vicodin?
Q. That could be one, yes. Have you ever heard of hydrocodone --
A. Yes.

Q. -- combination products?
What are they, as you understand them?
A. Synthetic opiates, opioids.
Q. Synthetic opioids?
A. Manufactured.
Q. Are you aware of products where hydrocodone is combined with another nonnarcotic ingredient, such as a cough suppressant or an analgesic, have you ever heard of such a product?
A. Like Tylenol?
Q. Right.
A. Yes.
Q. Do you know whether those type of products have ever been abused in Summit County?
A. Not to my knowledge. I don't know.
Q. Do you know of any attempt to measure whether hydrocodone-combination products have been part of the opioid crisis, as you have described it?
A. Not that I know of.
Q. Have you ever heard that anecdotally?

A. No.
Q. Are you aware of any measures taken by pharmacies to try to help decrease opioid diversion and abuse?
A. Well, I think they participate in OARRS.
Q. I'm sorry?
A. They participate in the OARRS program.
Q. Yes.
A. They have handed out the Deterra bags for us.
Q. Can you describe what those are?
A. It's a charcoal-containing, you add water and throw your pills in there, then when you seal it and squish it up, it dissolves the pills so they are inactive.
Q. And why is that helpful?
A. Because what it does is, when they dispense a prescription, then they can also give folks who aren't going to end up using the whole amount of it, to get rid of what is left over.
Q. So it helps reduce the amount of --
A. That's available for diversion,

yes.
Q. Okay. How about in distributing Narcan or naloxone?
A. Yes, they have done that as well.
Q. What can you tell us about the pharmacies involved in that program?
A. From what I know is they will -- some, I believe, even have given it away to -- that may have been free or low cost, but they have given away naloxone kits as a community service to help put Narcan in the community for overdose prevention.
Q. And how is that helpful?
A. It's helpful because we are in the prevention business, and if we can prevent a death, what it helps us do is give that person, once they are overdosed, once they are then revived with Narcan, it gives us or whomever an opportunity to seek treatment or help them get into treatment, if we can. They get a second chance of being able to be successful at fighting addiction.
Q. So that's a good thing?
A. That's a very good thing.
MR. LAVELLE: Can I have one

minute, please? Can we go off record for one minute.
THE VIDEOGRAPHER: Off the record at 3:51.
(Pause.)
THE VIDEOGRAPHER: On the record, 4:05.
Q. Commissioner, thank you. I have just one final, short area I wanted to cover with you, and then I'm going to pass the baton to counsel for AmerisourceBergen.
Did you receive a litigation hold notice in this case?
A. No.
Q. Do you know what one of those is?
A. No.
Q. You described earlier that you went through a process of collecting records and then turning them over to the attorneys; do you remember that?
A. Correct.
Q. Were you ever asked to preserve documents and not discard them, not throw them away?
A. You mean -- no. We wouldn't

anyway. We always have the documents. We would never throw anything away.
Q. I understand that. I'm just asking you whether you received a notice telling you to hold onto documents and not dispose of them?
A. Not to my knowledge.
MR. LAVELLE: Very good. Thank you very much, Commissioner. I'm going to pass the baton.
THE WITNESS: Thank you.
MR. LAVELLE: I appreciate it.
EXAMINATION OF DONNA SKODA
BY MR. SALIMBENE:
Q. Ms. Skoda, my name is Michael Salimbene. I represent AmerisourceBergen, another defendant in this lawsuit.
Do you know who or what AmerisourceBergen is?
A. No.
Q. Have you ever heard that name before today?
A. Yes.
Q. In what context?
A. Just as a name. I don't know anything about them though.

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Q. Okay. Did you speak at a press conference announcing this lawsuit to the residents of Summit County?
A. Yes, I believe so.
Q. What did you say, if you recall?
A. I don't remember.
Q. Who -- did somebody ask you to speak --
A. Yes. It was --
Q. -- at the press conference?
Who asked you to speak?
A. Ilene Shapiro.
Q. Who is Ilene Shapiro?
A. The county executive.
Q. Did you ask her, or did she tell you why she wanted you to speak?
A. I can't remember. They just wanted general health information as to why they were doing this.
Q. Did you prepare any written document to assist with your statement?
A. Not that I can remember.
Q. Do you remember roughly when, what month and year, you made the statement?
A. It had to be probably sometime in

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the late 2017, 6, 17 maybe.
Q. Is it fair to say the purpose of you giving a statement was to address, in part, why the county was filing a lawsuit?
A. No. It wasn't necessarily the county, but why public health was joining.
Q. And if you don't recall what you said then, what is the reason for public health joining?
A. We felt, our board of health felt, we have a board, they felt strongly that we needed to show support, and they were hopeful that there would be some injunctive relief to stop some of the behaviors that were creating some of these situations.
Q. What behaviors in particular?
A. Like overprescribing, the ability of -- not the ability of, but the number of pills that were available in the community, the ability for us to be trying to combat this without really knowing what the problem was.
Q. So one of the purposes was to curb overprescribing, you testified?
A. Yes.
Q. Are you aware that there aren't any

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prescribers named in this lawsuit?
A. Yes.
Q. How is it possible to curb overprescribing, using this lawsuit as a tool, if prescribers are not involved in the case?
A. I think it wasn't necessarily against physicians. It was all the behaviors that created this environment that allowed everybody to think that opioids were safe.
Q. Okay. But physicians actually do the prescribing, true?
A. That is true.
Q. And physicians are the individuals who operate so-called pill mills, which have been discussed today, true?
MS. KEARSE: Objection.
A. True, to my knowledge. I don't know much about pill mills because -- not tons, but...
Q. Does your department of public health have a mission statement or a set of goals, anything like that, a credo, if you will?
A. Yes.
Q. What is that?

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A. To protect and ensure the safety and health of citizens of Summit County, just kind of summarized.
Q. Is that available on your website, do you know?
A. Yes.
Q. Back to the decision to bring a lawsuit, you said there is a board, board of --
A. Health.
Q. Board of health, okay. So how did that, how did the process work? The internal decision, I'm not talking about conversations with counsel, was there a vote, for example?
A. No, we never actually had a formal resolution. The decision was meant that they talked about it, we talked about it at open board, they then agreed.
We talked about it -- first of all, our structure is that personnel in finance would have heard that conversation first. Personnel in finance had discussed that possibility of us joining the lawsuit with the county and other people, and they then agreed to move forward, brought it back to the full board and said, we wanted to support the county

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in the efforts, plus, again, the concern was they wanted to help mitigate the opioid crisis.
Q. Are you aware of any individual who was against bringing a lawsuit?
A. On my board?
Q. Just within the county in general.
A. No.
Q. Did anybody on your board express reservations in any way?
A. No.
Q. Do you know which drug distributors your county sued in this case?
A. No.
Q. Do you know how many there are?
A. No.
Q. I talked about AmerisourceBergen. Are you familiar with Cardinal?
A. Yes.
Q. Okay. And how so?
A. Cardinal actually has a series of grants that they put out, and we wrote for one of those grants and was successful.
Q. So Cardinal has provided funding to your county?
MS. KEARSE: Objection.

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A. Just recently.
Q. And in what context was the funding provided?
A. They had an open RFP process that was put out, and there were three different categories. We were in the one for community outreach and education. So they provided funding to us about -- I think it is close to maybe $80,000.
And they have also given us an AmeriCorps volunteer that allows us to do some recovery coach work, some education, some outreach, trying to help reach more clients, naloxone.
Q. Is that helpful to your efforts?
A. Yes.
Q. How about McKesson?
A. Do I know them?
Q. Yes.
A. Yes.
Q. What is context?
A. I think we do buy supplies from McKesson.
Q. Do you know anything about the distributors, AmerisourceBergen, Cardinal, and

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McKesson, do you know anything about their company policies with respect to the distribution of pharmaceutical products?
A. No.
Q. How about with respect to the distribution of opioids?
A. No.
Q. Do you have a general understanding of the pharmaceutical supply chain?
And I'll just say, so from the time somebody goes a doctor and is diagnosed with a condition, how it works that they end up with a medication to treat that condition?
MS. KEARSE: Objection.
A. Yes.
Q. Can you describe that for me?
A. Well, my understanding would be that the drug is manufactured somewhere, it would go to a supplier, and then it would go to a drugstore or pharmacy, and then it would come to the patient.
Q. Do you understand or have an understanding what a distributor does within the pharmaceutical supply chain?
A. Not probably clearly.

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Q. Do you know if distributors play any part in the manufacture of prescription drugs?
A. I am not sure.
Q. Do you know whether distributors promote prescription products to prescribers?
A. I'm sorry. Could you say that again?
Q. Sure. Do you know whether distributors promote prescription products to prescribers?
A. Not to my knowledge. I don't know.
Q. Okay. Do you have any knowledge about -- excuse me. Strike that.
Do you have any personal knowledge regarding any statements made by a distributor or its representatives in promoting opioid products to prescribers?
A. No.
Q. You mentioned earlier, I think, pain is the fifth vital sign?
A. Correct.
Q. Do you have any knowledge of any distributor defendant taking part in the origin of creating, you know, pain as a fifth vital

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sign, as you put it?
A. No, I do not.
Q. Do you know whether distributor defendants, and I'll just limit it to defendants named in this case, if that helpful -- is helpful, draft the warnings that accompany prescription medications?
A. No, I don't know that.
Q. Do you know whether distributor defendants interact in any way with patients in the course of their treatment with the physician?
A. Not to my knowledge.
Q. Do you know whether the distributor defendants in this case fill prescriptions written by physicians?
A. Not to my knowledge.
Q. Okay. Do you know if distributors named in this suit counsel patients about proper medication use?
A. Not to my knowledge.
Q. Do you know whether distributors named in this suit are licensed to practice medicine in Ohio?
A. I don't know. No, I don't know.

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Q. Sorry.
A. I just don't know.
Q. Do you know whether distributor defendants in this case have any role in creating drug formularies?
A. Not to my knowledge.
Q. Do you have any understanding of the way the DEA determines how many opioids are allowed to be manufactured in a given year, a quota process?
A. No.
Q. Do you have any understanding about whether distributor defendants in this case play any role in setting quotas for opioids?
A. No, I don't know that.
Q. I believe you testified in the previous line of questioning that you have had no interaction with distributor defendants; is that fair?
A. Correct.
Q. Fair to say then, you don't have any knowledge about a statement made to you by somebody who was a representative for a distributor defendant in this case?
A. Yeah. I don't know who it would be.

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Q. Do you know if a distributor knows the identity of the prescriber who actually writes a prescription for a given patient?
A. Not to my knowledge. I wouldn't think.
Q. Are you familiar with HIPAA?
A. Yes.
Q. And just in general, fair to say that is a law that's designed to protect confidential health information?
A. Yes.
Q. Do you know if distributor defendants have any information about the reason a medication is prescribed for a particular patient?
A. No.
Q. How about what that patient's diagnosis is?
A. No.
Q. How about how a patient pays for their prescription, in other words, if it's covered by insurance or they go to a pharmacy and pay with cash?
A. No.

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Q. How about whether a patient has tried and failed more conservative pain medications before getting an opioid, is that something that a distributor defendant would know?
A. Not to my -- I don't know. Not to my knowledge. I wouldn't think.
Q. How about whether a patient has a history of addiction?
A. Not to my knowledge, no.
Q. How about whether the defendant -- excuse me. Strike that.
Do you know if distributors are regulated?
A. No.
Q. Do you have any understanding of State of Ohio regulations applicable to distributors in this case?
A. No.
Q. Board of pharmacy regulations, any knowledge about those, as they apply to distributors?
A. No.
Q. Do you have an understanding of what a distributor defendant's legal

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responsibilities are with respect to controlled substances?
A. No.
Q. Have you ever heard of -- strike that.
Have you heard of the phrase, "suspicious order"?
A. No.
Q. You said earlier you read, "A tremendous amount," I think were your quotes?
A. Right.
Q. In that tremendous reading, as you put it, have you ever come across the phrase, "Suspicious order"?
A. No.
Q. Do you have any personal knowledge about anything related to suspicious order reporting by distributor defendants in this case?
A. No.
Q. Do you have any basis to dispute that every opioid medication shipped by a distributor defendant in this case was approved by FDA?
MS. KEARSE: Objection.

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A. I don't know that. I would have no way to know that.
Q. Do you agree that access to prescription medications is important for Summit residents?
A. Yes.
Q. I'm going to ask this as well. Are you aware of any link between a specific order shipped by a distributor defendant into Summit County and an individual who overdosed in this county?
A. No.
Q. Do you agree that if Summit County residents could not access prescription medications, it would be -- represent a problem for the general health for the residents of this county?
MS. KEARSE: Objection.
A. Perhaps, yes.
Q. So you mentioned earlier, I think, that you deal with people who have diabetes and cardiovascular disease, true?
A. Yes.
Q. Those conditions are treated with prescription medications, true?

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A. Correct.
Q. And if somebody with diabetes didn't have access to prescription medication that a doctor had prescribed them, that could be a problem for that individual, true?
A. Yes.
Q. Do you know who distributes medications into this county for people who suffer from diabetes?
A. No.
Q. Do you know that it is the same distributor defendants who have been sued in this case?
MS. KEARSE: Objection.
A. No, but it makes sense.
Q. Do you agree that your citizens are better off if they can fill prescriptions with the medications prescribed by their doctors?
A. Generally, yes.
Q. As the -- is your title commissioner or director?
A. It's health commissioner.
Q. Health commissioner. In Cuyahoga, commissioner was underneath the director.
A. Correct. That's the only one in

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the state. So don't worry.
Q. I like it better this way.
As commissioner of public health, who do believe should make decisions about which medications your citizens receive?
MS. KEARSE: Objection.
A. Who do I believe?
Q. Yes.
A. Personally?
Q. Yes.
A. It should be a partnership between the patient and whoever their provider is.
Q. You mentioned needle exchanges earlier, and I just want to follow up on that.
You said there is no patient identifying information; is that true?
A. Correct.
Q. So it's reduced to an identifying number?
A. Yes.
Q. Is there anything done within the county to track overdose rates for individuals who make use of your needle exchange program?
A. No. We couldn't. There would be no way.

Q. So it's fair to say you don't know whether individuals who pick up a syringe from Summit County's needle exchange program have a higher or lower overdose rate?
A. We don't know. They come back every week, so I don't think they are overdosing, if that makes sense, but really, that's just anecdotal.
Q. Right. I'm going to show you something.
MR. SALIMBENE: And I have one single-sided copy for the witness, for the exhibit, and then everybody else is going to have to deal with double-sided. I'm sorry, but I'm not that strong and I had a lot of paper.
MS. KEARSE: What number are we on?
MR. SALIMBENE: 12, I think.
I'm just going to mark this whole thing as 12.
- - - - -
(Thereupon, Deposition Exhibit 12, Email with Attachment, Beginning with Bates Label Summit 176307, was marked for purposes of identification.)

- - - - -
Q. Are you familiar with Summit County Opiate Task Force?
A. Yes.
Q. I think you testified a bit about it earlier today --
A. Yes.
Q. -- true? And that's one of the perils of going last. I have to keep up with the whole day.
MS. KEARSE: So does she.
MR. SALIMBENE: No kidding.
Q. When did you first learn about this task force?
A. It would have been 2014, 2015.
Q. And it's true that your department coordinates with this task force as part of your efforts to address opioid addiction; is that true?
A. Yes.
Q. And since when have you coordinated or your department coordinated with Summit County Opiate Task Force?
A. Since the inception. We were on some of the planning committee meetings.

MS. KEARSE: Can I ask a question? I know you handed this to her, but I don't see -- am I missing it? Is this an email to her?
MR. SALIMBENE: Well, it came through her custodial file.
MS. KEARSE: Okay.
MR. SALIMBENE: So it's from Darlene Migas, and then it is on behalf of her with no lines, so it is probably a BCC to a lot of people, was my assumption, but I was going to ask.
MS. KEARSE: I was going to say, if could you get that on the record.
MR. SALIMBENE: I will. Absolutely.
Q. Just looking at the first cover email to the attachment, and it is Bates number Summit 176307, and this is from Darlene Migas; did I pronounce that correctly?
A. Uh-huh.
Q. Is this an email you would have received?
A. Yes. Yeah. If it was in my files, I received it.

Q. So now if you look at the attachments, Summit County Opiate Task Force 2017 Through 18 Strategic Plan?
A. Yes.
Q. Are you familiar with this document?
A. Yes.
Q. Have you ever seen this document prior to today?
A. Yes.
Q. On page 2, the Strategic Planning Process?
A. Yes.
Q. The first sentence there says, "Summit County Opiate Task Force has made great strides in addressing the opiate crisis in the last few years"; do you see where I read that?
A. Yes.
Q. Do you agree with that statement?
A. Yes.
Q. Can you name the great strides that have been made in addressing the opiate crisis?
A. I think it's just they have just made an attempt to organize the work into categories, and they have been able to put in

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place additional funding for recovery, for all of the necessary tools that we need to try to ensure that individuals can get treatment and stay in recovery.

So they have been able to address the problem, from a multifaceted approach, in organizing all of these community partners to help us.

Q. And that's a good thing for the residents of Summit County, correct?

A. Yes. When they say "residents" though, they are residents, but most of these individuals are tied to an organization or agency. 100 Summit County citizens are task force members, but they are individuals that work in the field --

Q. Oh, sure.

A. -- most of them.

Q. I meant to say the task force's great strides are a good thing for the citizens of this county?

A. Yes. Oh, it's an excellent thing, yes.

Q. So here on page two, it says, third paragraph down, "The second phase of the

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planning process was to conduct an in-person strategic meeting in February of 2017 with key stakeholders to develop actionable items around the priorities identified through this survey process." Do you see where I read that?

A. Yes.

Q. And I should back up. This is a survey mentioned in paragraph 2. It says, "As part of the first phase of planning, various task force documents, including meeting minutes, data reports, and previous survey results were reviewed to formulate a new survey to assess priority issues regarding the opiate crisis for 2017 through 18." Do you see where I read that?

A. Yes.

Q. Did you ever review that survey?

A. I don't believe so.

Q. Okay. Do you know how folks were selected to take part in the survey? It says, "53 individuals provided their input."

A. I think it was just willing, those that would do it.

Q. Were those who would do it task force members?

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A. Yes.

Q. So then on page 3, it lists survey results. It says, second paragraph down, "The biggest area of concern from the survey was lack of access to treatment services."

Do you agree with that, that -- not that that was the biggest outcome from the survey, but do you agree that the largest area of concern is the lack of access to treatment and services?

A. There weren't enough beds to meet the need that was required for the addiction.

Q. Do you think that insurance companies choosing not to reimburse for addiction services contributed to the opioid crisis that gave rise to the lawsuit here?

MS. KEARSE: Objection.

A. No. I have not ever heard that. With Medicaid expansion in Ohio, we, in Summit County, dropped to about 30,000 individuals that were uninsured down from about 85,000. So there was a great number of individuals who picked up services -- or actually picked up insurance to get services, and then if -- let's say you don't have insurance and you need

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treatment, the ADM board will reimburse that facility. ADM, they pay for indigent care, uninsured.

Q. So if the individuals who had received -- not prescription, but received insurance coverage, was that part of that due to the Affordable Care Act?

A. Medicaid expansion --

Q. Okay. Medicaid expansion.

A. -- and affordable care for some --

THE NOTARY: Wait a minute.

MR. SALIMBENE: That one was my fault.

Q. So actually, I'll just back up and ask you a new question.

Do you know whether insurance companies, some insurance companies who cover residents in this county made the decision to not to cover rehabilitation treatment for people who were addicted to opioids?

MS. KEARSE: Objection.

A. Not to my knowledge. There is mental health parity in Ohio, so they had -- most insurance plans had to cover -- I mean, they all covered mental health treatment.

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Q. Okay. So the next paragraph down says, "The second most frequently mentioned area of concern was the need for prevention services to get in front of the problem." Do you see where I read that?
A. Yes.
Q. So, "Respondents mentioned the need for prevention of experimentation by young people, misuse of prescriptions, prevention use of illegal substances and preventing overprescribing." Do you see where I read that?
A. Yes.
Q. Now, misuse of prescriptions, that is something that takes place on the individual level, true, the individual who is actually misusing the prescription medication?
A. It would be an individual doing it, yes.
Q. Right. And overprescribing is something done by a physician or an individual who has prescribing power in the State of Ohio, true?
A. Yes.
Q. Do you agree there is nothing

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listed here about any of the conduct of a distributor defendant in this lawsuit?
A. Yes, if I knew exactly what a distributor did. If you could explain that.
Q. Well, I'm just saying there is nothing listed here --
A. No.
Q. -- to your knowledge that applies to a distributor of pharmaceutical drugs, true?
A. Except maybe preventing the overprescribing if they are being shipped.
Q. But they are not prescribing, true?
A. Yes. True.
MS. KEARSE: I think the witness asked for clarification for your term "distributor."
A. Yes.
MS. KEARSE: If you want to --
Q. Well, it's a company that distributes pharmaceuticals that were sued in this case?
A. Right. But you are distributing them to pharmacies and --
Q. Correct.
A. Okay.

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Q. "Two other," the next paragraph down, sorry.
"Two other areas that came out as tying for the third priority, were the number of overdoses and the number of people dying by overdose, and the need of various segments of the public for education. The topics for education needed were: Addiction as a complex, chronic brain disease; the role of law enforcement in behavioral health; the dangers of experimentation with opiates; how to access help; and that there are things working to make the problems better in the community." Did you see where I read that?
A. Yes.
Q. And there is nothing in these survey results that mention suspicious order reporting in any way; is that true?
A. Correct.
Q. And if you look at page five of this document, at the top there is a heading Strategic Goals, and then it says, "Following are the goals selected for action planning by the workgroups." Do you see where I read that?
A. Uh-huh.

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Q. And it lists 11 items, and I'll give you a chance to look them over but -- and let me know when you have.
A. Okay.
Q. Do you see number 8 says, "Reduce access to heroin/other illegal opioids"?
A. Yes.
Q. Do you agree that this list under strategic goals doesn't say anything about legal prescription opioids?
A. Yes.
Q. Do you agree that this section does not say anything about distributors of prescription opioids?
A. Yes.
Q. Do you agree that this section doesn't say anything about suspicious order reporting?
A. Yes.
Q. And I'm finished with that document.
- - - - -
(Thereupon, Deposition Exhibit 13, Email with Attachment, Beginning with Bates Label Summit 131869, was

marked for purposes of identification.)

- - - - -

Q. Marked here as Exhibit 13 is Summit 131869 and an attachment. It is from Gene Nixon to you, dated October 2014, correct?

A. What date did you say?

Q. October 2014.

A. Oh, yeah, yes, yes.

Q. Maybe I didn't say that but --

A. No, I thought you said April, and I was like, is that April?

Q. Gene Nixon, remind me who that was, the previous health commissioner?

A. Yes.

Q. And the attachment, which is the next page there, By the Numbers, Scope of the Problem. Do you see where it says that at the top?

A. Yes.

Q. Do you know who drafted this document?

A. It would have been Gene.

Q. Did you -- or let me just ask this. Do you know why he sent it to you?

A. I used to proof his work. So we shared documents back and forth to proof, so I'm sure he sent it to me to read. He must have been doing something with this.

Q. If you look four paragraphs down, the last sentence -- the previous sentence speaks to, "Prescription opiates, i.e. pain medication," and then it says, "These addictive pain medications are being diverted to street economy in alarming proportions due to overprescribing." Do you see where I read that?

A. Yes.

Q. And did you -- do you recall ever emailing or speaking with Gene Nixon and disagreeing with that statement?

A. No, because I probably read this, checked it for errors, spelling, and sent it back to him.

Q. Do you agree that in this document from the acting -- or the then health commissioner, there is no mention of suspicious order reporting in any way?

A. Yes.

Q. Is it true that you have given

presentations on what you termed the opioid -- excuse me, the opiate epidemic?

A. Yes.

Q. I'm going to mark this one as Exhibit 14.

A. This one is not marked. Do you want to mark it?

Q. Oh, it was supposed to be clipped with the previous --

A. Oh, I'm sorry.

Q. No, I'm sorry.

- - - - -

(Thereupon, Deposition Exhibit 14, Email with Attachment, Beginning with Bates Label Summit 135023, was marked for purposes of identification.)

- - - - -

Q. So what is marked as Exhibit 14 is an email from Richard --

A. Marountas.

Q. Marountas, thank you, to you, and the subject is opiate epidemic, and that's Summit 135023; do you see that?

A. Yes.

Q. And then if you look at the attachment, the opiate epidemic PowerPoint, I believe?

A. Yes.

Q. And it says, "Presentation to the Child Family Leadership Exchange," and that's your name there, true?

A. Yes.

Q. Do you know if you drafted this PowerPoint presentation?

A. No, I did not.

Q. Did you present the actual presentation?

A. Yes.

Q. Would you have reviewed it to make sure it was accurate?

A. Yes, usually. It depends on the time, but usually I do.

Q. You wouldn't go and present to the Child Family Leadership Exchange information that you did not believe to be accurate, correct?

A. Correct.

Q. If you look at -- let me ask this. Do you recall, or was it your typical practice,

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I should say, when you have a PowerPoint like this, are there speakers note? You know how sometimes in PowerPoint you have a little section -- you just wing it? Good for you.

MS. KEARSE: Objection.

Q. Actually, you know what, strike that. I didn't mean to be pejorative in that, with saying that.

I just meant that you just will work with your slides --

A. Correct.

Q. -- and go from your mind. I did not mean to make that sound offensive.

If you look at -- now, there are no slide numbers, and I don't know who we have to blame for that, but if you look at the section that begins Solutions to the Opiate Epidemic, and it is about, I would say, maybe halfway through the presentation -- towards the end of the presentation actually, closer to the end, I believe.

A. I see.

Q. About four pages from the end.

And the first slide has to do with naloxone -- the first two slides have to do

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with naloxone, true?

A. Let me find them.

Q. Sure. Yes. And it looks like this.

A. Yeah. Project DAWN. Right. Okay. D-A-W-N.

Q. Well, actually, prior to that slide, I think, there is one before it.

A. Oh, yes.

Q. Okay. And so the first of the slides for the solutions to the opioid epidemic concern naloxone, true, the first two slides?

MS. KEARSE: There may be a slide before the first one.

A. Yes.

Q. And then there is a slide on Project DAWN, correct?

A. Yes.

Q. And then the last of that type -- excuse me. There is another slide on the DUMP Program; do you see where I read that?

A. DUMP, yes.

Q. And then the last slide has to do with Other County Initiatives; do you see where I read that?

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A. Yes.

Q. Do any of the solutions proposed in your PowerPoint here have anything to do with suspicious order reporting done by distributor defendants in this lawsuit?

A. No. This was mostly geared for public health interventions, so we didn't get into any other solutions that might be possible.

Q. Do you agree that the -- and you can put that aside, thank you -- the number of prescription opioids dispensed is lower today than it was in 2012?

A. Yes.

Q. Do you agree that today there are more overdose deaths in Ohio due to illegal opioids than prescription opioids?

MS. KEARSE: Objection.

A. I don't really know that.

Q. Have you ever reviewed the Ohio drug overdose data statewide?

A. Ohio Department of Health document?

Q. I'll show it to you.

A. Okay.

Q. I don't mean to put you on the

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spot.

- - - - -

(Thereupon, Deposition Exhibit 15, 2015 Ohio Drug Overdose Data: General Findings, was marked for purposes of identification.)

- - - - -

Q. So Exhibit 15 is titled 2015 Ohio Drug Overdose Data: General Findings from the Ohio Department of Health?

A. Yes.

Q. Have you ever seen this document before?

A. I believe so.

Q. Is it something you reviewed as part of your role as health commissioner in Summit County?

A. Probably in 2015 -- it was labeled 2015, I don't know when we received it though, so that's what I'm kind of struggling with, to know when we looked at it, but, yes, we probably -- I reviewed it.

Q. Okay. Do you see, there is a chart, it's figure 4, it's on page 3, at the bottom?

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A. Yes. Yes.
Q. And there is a little blurb to the right that says, "The percentage of prescription opioid overdose deaths decreased in 2015 for the fourth straight year." Do you see where I read that?
A. Oh, yes, I did, yes.
Q. Okay. Now, if you look at that figure 4, the deaths from fentanyl and from heroin, which is a green bar for 2015, which is when this was reported, are those higher or lower than the percentage due to prescription opioids?
A. Lower -- or higher. I'm sorry, higher.
Q. It was your opinion at around this time that the decrease in prescription opioid usage, in terms of pills dispensed, was a good thing, correct?
A. I'm sorry. Could you say that again.
Q. Sure. That was terrible.
Around this time in 2015, you believed that the decrease in the number of prescription opioids dispensed was a good

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thing; is that fair to say?
MS. KEARSE: Objection.
A. Yes.
Q. And if you look at the figure 9 on page 7, which says, number of, quote, doctor shoppers, Ohio, 2011 through 2015; do you see where I read that?
A. Yes.
Q. And then a little asterisk says, "A doctor shopper is defined as an individual receiving a prescription from five or more providers in one calendar month." Do you see where I read that?
A. Yes.
Q. And doctor shoppers, according to this chart, drop every year from 2011 to 2015, correct?
A. Yes.
Q. Do you agree that doctor shoppers bear some responsibility for the opioid crisis that gave rise to this lawsuit?
MS. KEARSE: Objection.
A. No.
Q. And why not?
A. Because I believe once you are

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addicted and if you have been given a legitimate prescription for which you take, and then people doctor shop because they have to get more because of the addiction.
So it's like they are addicted, and so they start to make bad decisions and go to multiple physicians or nurse practitioners or whomever, so that they can continue that habit, because they are addicted.
And their own doctor may have said, no, this is all you can have, and then they go out and seek pills from other places, but it's in relationship to that addiction that they have.
Q. You're speaking very generally. Are you basing what your answer was there on any specific facts that you are aware of?
A. Again, it would be conversations with individuals and understanding drug-seeking behavior and having spent 30 years in the -- basically in the streets with drug users and individuals who have abused medications.
Q. And there are individuals who sell medications illegally to individuals, correct, including prescription-only opioids?

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A. Yes. But it would be a rare bird, I have never seen one that wasn't a user as well.
Q. Okay. But do you have any data that says what percentage of these doctor shoppers here are individuals who were using the pills versus individuals who took the pills and sold them on the streets?
A. No, I have no idea.
Q. Okay. If you look at page 8.
A. Yes.
Q. And it is table 1, Unintentional Drug Overdose Deaths of Ohio Residents Involving Specifics Drugs, as Mentioned on Death Certificate, By Year. Do you see where I am?
A. Uh-huh.
Q. If you look at some of these categories, let's start with, say, benzodiazepines, from 2003 to 2015, there is an increase from 38 deaths to 504, correct?
A. Yes.
Q. And if you look at cocaine, cocaine is up from 140 in 2003 to 685 in 2015, correct?
A. Correct.

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Q. And alcohol goes from 40 in 2003 up to 380 in 2015 --
A. Yes.
Q. -- correct?
Hallucinogens goes from 7 to 61 from 2003 to 2015, correct?
A. Yes.
Q. Are benzodiazepines, cocaine, alcohol, hallucinogens, are any of those opioids?
A. No.
Q. Have you ever undertaken an analysis as to why there is an increase in, say, alcohol-related deaths, going from 40 to 380, so just about a nine times increase over a 12-year period?
A. No.
Q. Would the same be true with respect to cocaine?
A. Yes.
Q. And would the same be true with respect to hallucinogens?
A. Yes.
Q. Would the same be true with respect to benzodiazepines?

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A. Yes.
Q. Did you discuss with anybody, aside from counsel in this lawsuit, about bringing a lawsuit related to manufacturers of alcohol products, alcohol-containing products?
MS. KEARSE: Objection.
A. No.
Q. Do you agree that the distributor defendants you sued in this case do not distributor cocaine?
MS. KEARSE: Objection.
A. Yes. I would assume not.
- - - - -
(Thereupon, Deposition Exhibit 16, 2016 Ohio Drug Overdose Data: General Findings, was marked for purposes of identification.)
- - - - -
Q. So what the court reporter has marked as Exhibit 16 is the 2016 Ohio Drug Overdose Data: General Findings. Do you recall reviewing this report prior to today?
A. No.
Q. Is this the same sort of report that we just looked at, but just now for 2016,

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same data set?
A. It could be. Yes, I would think.
Q. If you look at the last sentence of the first paragraph, it says, "The data also shows some promising progress, the fewest unintentional overdose deaths involving prescription opioids since 2009, excluding deaths involving fentanyl and related drugs." Do you see where I read that?
A. Yes.
Q. Do you agree that that is promising progress?
A. I really don't know. I would have to think about it. I mean, yes, but I don't know where that data comes from though, to be honest. I just don't know.
Q. Okay. Well, if you look at figure 2, it is the Percentage of Unintentional Drug Overdose Deaths Involving Select Drugs By Year, and at the bottom, it says, Source: Ohio Department of Health, Bureau of Vital Statics --
A. Okay. They're tracking, okay.
Q. Okay. Is that a reliable source?
A. Yes.

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Q. So do you believe that the fact that the Ohio Department of Health, Bureau of Vital Statistics is reporting that the fewest -- reporting the fewest unintentional overdose deaths involving prescription opioids since 2009, do you view that as promising progress?
A. It's a good thing, yes.
Q. And if you look at page 3, the last paragraph of the page, where it says, "Opioid prescribing in Ohio declined for a fourth consecutive year in 2016, according to the State of Ohio Board of Pharmacy, see figure 6. Between 2012 and 2016, the total number of opioids dispensed to Ohio patients decreased by 162 million doses, or 20.4 percent." Do you see where I read that?
A. Were you on page 4?
Q. I'm on page 3. I'm sorry. Did I say page 4?
MS. KEARSE: I don't know. I don't think any of us knew where you were reading.
Q. It's the last paragraph on that page.
A. Is that a per capita number, or

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just a general, in total, number? Just general, okay.
Q. I don't know. I'm not going to make any representations, other than what's written there.
A. Yeah. It's a good thing.
Q. Okay. Now, if you look at table 1 on page 6, which is now the Number of Unintentional Drug Overdose Deaths Involving Specific Drugs As Mentioned on Death Certificate, by year, 2004 through 2016. So again we are looking at the same table for 2016 that we just looked at for 2015, true?
A. Yes.
Q. Okay. Now, if you look at cocaine, in 2016, according to the Ohio Department of Health, Bureau of Vital Statistics, there are 1,109 deaths due to cocaine in 2016 alone; do you see that?
A. Yes.
Q. Is it true that the deaths due to cocaine in 2016 are higher than the deaths due to prescription opioids for any year listed here in this chart for 2004 to 2016?
A. Yes.

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Q. And it is also true as of 2016, the percentage of deaths attributable to cocaine are about double the percentage of deaths attributable to prescription opioids; is that correct?
A. I'm sorry. Say that again.
Q. Sure, sure. Let me just -- so you can see underneath cocaine, it lists prescription opioid deaths?
A. Yes.
Q. It says 564, correct?
A. Yes.
Q. Which is down from the previous year of 667, correct?
A. Correct.
Q. And cocaine in 2016 is 1,109, correct?
A. Correct.
Q. So you would agree with me that the deaths attributable to cocaine were roughly two times the deaths attributable to prescription opioids in 2016?
MS. KEARSE: Objection.
A. Yes.
Q. And cocaine is not an opioid,

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correct?
A. Correct. But it could have been mixed with an opioid, but I doubt in this chart, but they used all confirmed data so...
Q. Right. And there are opioids listed on this chart, such as fentanyl and heroin, correct?
A. Uh-huh.
Q. So is there any basis for you to make the assumption that the cocaine deaths listed on this chart may involve another substance?
A. No, because I think -- I'm sure the Ohio Department of Health used the vital statistics, they used the final death record, so hopefully it was defined across the state.
Q. Okay. And three up from the bottom of this chart, there is a category for multiple drug involvement?
A. Okay. That would be, yeah, that's probably what was more -- that's what I was looking for, because often they are mixed.
Q. And you testified earlier that you have not conducted any investigation into why cocaine deaths are increasing at the rate they

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are; is that true?
A. Yes.
Q. And if you look at this chart here, alcohol, from 2015 to 2016, we see that metric going from 380 deaths to 539, correct?
A. Yes.
Q. And, again, you testified that you have not conducted any analysis into why alcohol deaths are increasing at the rate they are; is that fair?
A. Yes.
Q. Would the same be true with methamphetamines, and I'll just -- strike that.
So methamphetamine is a psychostimulant, it's categorized as here?
A. Right.
Q. It goes from 96 to 233, correct?
A. Correct.
Q. The same is true as of 2016 -- actually, strike that.
As of -- even to present day, you have not conducted any analysis as to why psychostimulant death rate has increased year over year; is that fair?
A. Yes.

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Q. Would you agree that based on this chart, table 1, 2016 and the 2016 Ohio drug overdose data, Summit has a growing nonopioid problem?
MS. KEARSE: Objection.
A. Now, where?
Q. Sure. Well, let me just back up. If you look at, again, 2015 to 2016 --
A. Right.
Q. -- just focusing on that one year.
A. Right.
Q. Cocaine deaths go from 685 --
A. Right.
Q. -- to 1109 --
A. Right.
Q. -- true?
And benzodiazepines go from 504 to 553, true?
A. Yes.
Q. And alcohol goes from 380 to 539, true?
A. Correct.
Q. Psychostimulants go from to 96 to 233, true?
A. True.

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Q. Hallucinogens go from 61 to 100, correct?
A. Correct.
Q. So that's increases in all those categories, correct?
A. Yes. Those are raw numbers. So I don't know if the rates have changed actually.
Q. Okay. But the year --
A. That's my concern, and probably the bigger concern I have, and why I'm kind of hesitating on this, when it says multiple drug involvement, that's defined somewhere, because what we are seeing now is any sort of an opioid mixed with cocaine, an opioid mixed with methamphetamine, carfentanil mixed with cocaine.
So we see these mixtures, so I'm not real sure that -- I get the whole multiple drug involvement, but I'm not real sure, and I want to be accurate. So I think these are raw numbers, not rates. So I don't know if they are really increasing.
Q. Okay. Well, let me --
A. If you get what I'm saying.
Q. I do, and let me rephrase my question.

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A. Okay.
Q. I'm just now talking about the absolute year-over-year total --
A. Okay.
Q. -- for cocaine, benzodiazepines, alcohol, psychostimulants and hallucinogens --
A. Yes.
Q. -- has increased year or year over from 15 to 2016, correct?
A. Yes.
Q. And the year-over-year total for deaths attributable to prescription opioids has decreased year over year from 2015 to 2016, true?
A. Correct. The raw numbers have decreased.
MS. KEARSE: Mike, I think meant the growing -- you insinuated for Summit, right?
MR. SALIMBENE: No, I don't think I did. I think I said Ohio.
MS. KEARSE: The last question you did, so I want to make sure the record is correct.

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Q. And let me just ask, do you have any basis to say that the trends noted for Ohio at large would be any different within Summit County?
A. The only statement I would make in this response is if you look at Summit County as a separate county from all issues, we probably trend more like the federal-level data than we do the local.
Q. Well, is it fair to say --
A. Ohio.
Q. Is it fair to say you are not aware of any data that suggests Summit County is experiencing trends different from the State of Ohio, with respect to the information in table 1?
A. Correct.
MS. KEARSE: Objection.
- - - - -
(Thereupon, Deposition Exhibit 17, Email Chain, Bates Label Summit 271615, was marked for purposes of identification.)
- - - - -
Q. So marked as Exhibit 17 is an email

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from Donna Skoda to Mmcneely@BathTownship.org; do you see that?
A. Yes.
Q. The first email, I should say. The chain originates with an email from Michael McNeely to you?
A. Right. He was the police chief.
Q. And he was asking you -- and this email, I should say, is dated April 6, 2011, correct?
A. Yes.
Q. And he's asking you, "Hi Donna, do you have any statistics on the improper use of prescription medications in Summit County? I am especially interested in numbers on the teen population."
And then the last paragraph says, "I have a media interview on this topic tomorrow afternoon"; do you see that?
A. Yes.
Q. And you forwarded the email to Richard Marountas, correct?
A. Yes.
Q. And Richard replied to you, correct?

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A. Correct.
Q. And then you replied to Mr. McNeely, at the top of the chain, correct?
A. Correct.
Q. And as part of your email, you wrote, the fourth sentence, "We do know that unused prescriptions are a source of drugs for teens and others. Also, accidental overdose is on rise from abusing prescription drugs," correct?
A. Correct.
Q. So unused prescriptions as a source of drugs, that would be diversion, correct?
A. Yes.
Q. And you say you knew, or I should say, it says, "We do know," it says, and one of the things here is, "Accidental overdose is on the rise from abusing prescription drugs," correct?
A. Correct.
Q. Is it fair to say that as of April 2011, you were aware that there was an issue with accidental overdoses rising, secondary to abusing prescription drugs?
A. Yes. I probably knew about it, but

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it wasn't anything I was responsible for.
Q. I just want to ask you a few more questions about the OARRS database.
Do you know what the purpose of the OARRS database is?
A. Yes.
Q. And what is it?
A. It was created as a tracking mechanism for individuals that are prescribed opiates, and then in order to help pharmacists and physicians know if there are any behaviors going on that are like doctor shopping.

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(Thereupon, Deposition Exhibit 18, Printout from the OARRS Website, was marked for purposes of identification.)

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Q. So I just marked as Exhibit 18 the printout of the web page, if you go to the main OARRS website here, and this statement here, "About." And then it says, "What is OARRS?"
A. Right.
Q. If you look at the last sentence on the first page, it says, "Drug wholesalers are

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also required to submit information monthly on all controlled substances and gabapentin sold to an Ohio licensed pharmacy or prescriber." Do you see where I read that?
A. Yes.
Q. Were you aware of that requirement prior to today?
A. I knew there were general rules, but I didn't know specifics.
Q. Do you have any basis to dispute that the distributors named as defendants in this case complied with the requirement articulated here?
MS. KEARSE: Objection.
A. I have no idea if they complied.
Q. Do you agree that the majority of people who take prescription opioids do not become addicted?
MS. KEARSE: Objection.
A. No.
Q. So it's your testimony that the majority, that would be over 50 percent of people who receive a legitimate prescription for an opioid become addicted to opioid medications?

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A. I wouldn't know the exact percentage, but I can tell you that it's high, extremely high.
Q. Do you have any basis to support the statement that greater than 50 percent of people who receive a prescription opioid, a valid prescription from a doctor, end up as addicts?
MS. KEARSE: Objection.
A. What is a "valid prescription"?
Q. Well, a prescription from a doctor. So let's just back up.
An individual who goes to a doctor and has knee pain, say, and the doctor gives him or her a prescription for oxycodone. So you get a prescription from a legitimate DEA-licensed doctor, that of those people, the majority of them become opioid addicts?
A. I don't know the percentage, but I would say the risk is great.
Q. Do you know what percentage of individuals who receive a prescription for opioids end up dying from an overdose?
A. No.
Q. Have you ever undertaken that

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analysis?
A. No.
Q. Do you agree that the majority of opioid users never try heroin?
A. I don't know that.
Q. Do you agree that the majority of opioid users never try fentanyl?
A. I don't know that either.
Q. Do you agree that the majority of opioid users never try carfentanil?
A. I don't know.
Q. Does Summit County have in place any program to make sure that patients who are in pain can access prescription opioids if those opioids are lawfully prescribed to them?
MS. KEARSE: Objection.
A. Does Summit County have any programs?
Q. Yes.
A. You mean Summit County Public Health or the government?
Q. Just in general, in the county, any program in the county?
A. Oh, I think that the hospital systems do.

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Q. Does your department of public health make any effort to ensure that opioids are available to Summit County residents who receive a valid prescription for them?
A. No.
Q. Do you agree with the statement that an individual has responsibility for their health?
A. Yes.
Q. Do you agree that individuals -- let me back up.
Do you agree that there is an element of personal responsibility in addiction when you look at the first time an individual chooses to take a prescription opioid without a prescription?
MS. KEARSE: Objection.
Q. So before they become addicted, and they make the decision to go out on the street and buy OxyContin without a valid prescription?
MS. KEARSE: Objection.
A. That's not been my experience with what happens. So I don't know of anybody who starts out and just goes out and buys an OxyContin on the street.

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If they were given a prescription from a prescriber and they start taking it, it has been my knowledge that within a short while, they continue to like that feeling, that euphoric feeling, and they continue, and then they -- once that happens, it doesn't take a great deal of time to become addicted.
Q. So let's focus on the --
MS. KEARSE: I think you just cut her off.
Q. Did I?
MS. KEARSE: Were you finished?
Q. I thought you were done. I'm sorry.
A. No -- yeah, that's good. I'm done.
Q. Okay. I thought you were. I'm sorry.
So let's look at the teenagers and the young people who divert pills from, say, a relative's medicine cabinet.
A. Yes.
Q. Is it your testimony that the majority of those children who use opioids first had a prescription for opioids?
A. No, but that's a very different

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group of individuals with experimentation. And what we know now about brain chemistry is that children, youngsters to about -- boys to about 23 or 24, and females, 22, 23, brain growth and development isn't complete, their ability to make good decisions isn't complete, and quite frankly, risky behaviors in youth experimentation is a part of growing up.

We don't encourage it, and certainly you hope the resiliency factors are there to teach children to make better decisions, but I don't think that -- that's a very different scenario with kids experimenting than it is with adults.

Q. You testified earlier that data you have seen suggests that four and five heroin users first received a prescription for opioids?

A. Four out of five.

Q. Four out of five, right.

So what about the one in five who did not, is there any personal responsibility for that individual who sought out heroin and used heroin?

MS. KEARSE: Objection.

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A. I'm not sure what you are asking me. Was there personal responsibility for becoming addicted? It is a brain disease. It's like blaming a diabetic for becoming a diabetic. It's not because they ate cookies and candy. It could be because of weight gain, but it is very different. You can't blame somebody for developing a disease.

Q. I'm talking about before the first time any substance has been used. There is a first time an individual uses heroin, correct?

A. Only after a long history. Individuals who use heroin don't go to the street and buy heroin today and decide to use it. It isn't like that at all. Maybe I'm missing what you're asking me.

Q. No, no. I'm just trying to make a very basic statement that for every heroin user, there is a first time they inject heroin, correct?

A. Correct.

Q. Okay. And you said that four out of those five of those individuals have first used a prescription opioid, correct?

A. Yes.

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Q. So I'm saying, let's focus on the one in five who did not.

A. Right.

Q. Is there any personal responsibility for that individual from making the decision to use heroin that very first time before they were addicted to heroin?

MS. KEARSE: Objection.

A. And I guess what I'm not saying well is, they wouldn't be getting heroin if they weren't addicted. Heroin is just, for some, a natural progression.

So they are getting into -- they couldn't get this drug, they may have used heroin, but once you are addicted, individuals will do unbelievable things to maintain that addiction, including using heroin. It's a brain disease. No one chooses to be addicted.

Q. Is it your testimony that individuals within Summit County who engaged in prescription opioid diversion bear no personal responsibility for their decision to divert opioids?

A. Are you talking about the sale of opioids?

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Q. I'm talking about the individuals who, without a prescription, use opioids in an unlawful manner, be it prescription opioids, for which they had no prescription, heroin, fentanyl or carfentanil.

A. Right.

Q. Is it your testimony the that those individuals have no personal responsibility for that decision?

MS. KEARSE: Objection.

A. No, I'm not saying that.

Q. So is it fair to say they do bear some personal responsibility for those decisions?

A. No.

Q. So I'm confused now.

A. Yeah, because I see it very much in a disease model, and I don't think they would be engaging in those behaviors if they weren't addicted.

Now, whether they got addicted via something else and started down that road, or whatever the progression has been, individuals who are addicted with a substance-use disorder use multiple substances, and they end up at a

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point where taking that oxycodone out of the medicine cabinet or stealing that drug is no different.

Some of them, if you look at some of the literature, they take it because of pain and get addicted accidently. They may have a legitimate pain and get addicted, they take it for the high maybe, but the bottom line is, that addiction is somewhere in that tale of woe for that individual.

Q. Is there any level of personal responsibility for an individual who chooses to use heroin?

MS. KEARSE: Objection.

A. Only in the act could be -- yes, there is personal responsibility for everything you do.

But I think you need to understand that there is a brain disease here. They can't, in some ways, understand what they are doing. The brain is powerful.

MR. SALIMBENE: I'm going to move to strike anything towards the end of that, which frankly -- starting with, "But I think you need" --

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MS. KEARSE: You want to cut off where you just want her to stop, but she answered your question, so...

MR. SALIMBENE: Okay. Well, you can make whatever -- I'm just going to move to strike that answer as it begins with, "But I think."

MS. KEARSE: And I'll say she was explaining her answer. She was answering your question, and you are trying to strike the part you didn't like.

MR. SALIMBENE: Okay. Can we hop off the record just pop out for a minute.

THE VIDEOGRAPHER: Off the record, 5:15.

(Recess taken.)

THE VIDEOGRAPHER: On the record, 5:23.

Q. Commissioner Skoda, can you pull up Exhibit 14, quickly. It is the PowerPoint presentation that you presented. It's clipped to the back of an email.

A. Thank you.

Q. And if you flip one of the slides in the middle of the presentation, it's titled

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Facts and Figures, Continued.

A. Yes.

Q. And if you look at the fourth bullet down, it says, "Four in five new heroin users started out misusing prescription painkillers." Do you see where I read that?

A. Yes.

Q. And the source is an article by an author named Jones, Heroin Use and Heroin Use Risk Behaviors Among Nonmedical Users of Prescription Opioid Pain Relievers.

A. Correct.

Q. Is it correct that you are not able to say today what percentage of those four heroin users started out having received a prescription for opioids?

In other words, you are not able to say what percentage purchased opioids illegally, compared to the percentage who first received a legal prescription for opioids?

MS. KEARSE: Objection.

A. Correct.

Q. Is it your testimony that heroin users in Summit County bear no personal responsibility for their decision to use

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heroin?

MS. KEARSE: Objection.

A. Yes.

MR. SALIMBENE: Does anybody else? I'm getting some blank stares. Nobody looks very enthused.

A. Sorry.

Q. That's a good thing for you.

MR. SALIMBENE: We're good? Okay. We're finished. We will pass the witness.

MS. KEARSE: Okay.

EXAMINATION OF DONNA SKODA

BY MS. FITZPATRICK:

Q. Ms. Skoda, I'm Fidelma Fitzpatrick. We've met a couple of times, and I just want to ask you a few questions at the end of the deposition and, hopefully, this won't take too long to run through.

A. Okay.

Q. You are the Summit County Commissioner of Public Health, correct?

A. Correct.

Q. And how long have you been in that position?

A. Three years.

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Q. Can you tell us what public health is?
A. It is a complex system of public health entities, local boards of health, that work in collaboration with any number of partners in the community to deliver services that reduce risk and harm and prevention in the communities.
Q. And is part of your job as the commissioner of public health to determine whether a particular health situation or a particular situation within Summit County is a public health issue or a public health crisis?
A. Yes, at times it is, it's appropriate, but it's usually, for us to determine a public health nuisance or a public health crisis, it's done in partnership with many of our partner entities, because these issues that are public health concerns are complex in nature.
And so we usually begin with a very thorough review of data and information and try to identify who is at most risk within the population. It is not geared at individuals. It's geared at preventing harm and any

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condition in the entire community.
Q. Is a public health issue different than an individual health issue?
A. Yes.
Q. Can you explain that to me?
A. An individual seeks medical care -- or has care one on one. Public health doesn't look -- that's why the data sources that we collect, much of what we get are deidentified, it's aggregate data, because our concern is what is this problem or potential problem creating in the community.
We aren't looking at it from an individual basis, but rather how do we address the needs of all and reduce harm and risk.
Q. And what makes something a public health issue or a public health crisis?
A. Something where, for public health particularly in this network, is we become very concerned when we see rising death rates, when we understand that the situation is now different from the perspective in the community, whether a use perspective or that things are now changing.
Another example of that might be

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climate change. We become concerned when see things that are changing in the community that can have adverse effects on the population.
Q. And earlier today, you were asked about patient-specific records a couple times; do you remember that?
A. Yes.
Q. And when determining whether something is a public health issue for Summit County, do you ever rely on patient-specific records or patient-specific information?
A. No, we do not.
Q. And why not?
A. Because that's not public health. We are into prevention for populations. We don't identify individuals or what their behaviors are.
We, unfortunately, with limited resources, deal with what we see in the community, as best we can, to try to mitigate damages that harm the people, and try to make sure that people can be successful and live and be healthy.
Q. Do you rely on aggregated data when making a determination whether something is a

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public health issue in Summit?
A. Yes.
Q. And you testified earlier today in response to some of the defendants' questioning, that there is an oversupply of opiates into the Summit County community; do you remember that?
A. Yes.
Q. And as the commissioner of public health, and with the experience that you bring to that position, do you believe that the oversupply of prescription opioids in Summit County has created a public health crisis?
A. Yes.
MR. NAEEM: Object to form and foundation.
Q. And why is that?
MR. NAEEM: I objected to form and foundation.
Q. Why do you believe that the oversupply of prescription opioids into Summit County has created a public health crisis?
MR. NAEEM: Same objections.
A. Because any time there are behaviors -- or there is such a trust with the

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medical community and with the organizations.
So any time there is a potential breach of that trust to the public -- people go to their doctor and believe that what they are doing is right, and when an individual physician prescribes a medication to a person, they trust at all levels that that is what should be happening to them.
And I refuse to believe, in my heart of hearts, that physicians don't think they are doing right. They are doing what they have been told to do. They were told to evaluate pain as a fifth sign, a vital sign.
Their professional organizations were are telling them, it's okay, go ahead and prescribe, and then all of a sudden we have this whole new group of individuals that are using opioids incorrectly and/or become addicted to them, and it has created havoc, and that is a kind word, for the communities.
Q. Is the opioid public health crisis of Summit limited to any particular socioeconomic group?
A. No.
Q. Is it limited to any particular

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gender?
A. No.
Q. Is it limited to any particular age group?
A. No.
Q. Is it limited to any particular ethnicity?
A. No.
Q. Why isn't this just an individual issue for individuals who are dependent on opioids?
A. Because it's impacting community resources, it's creating death and disability for which public health does everything in our power to prevent death and disability with policies, changes, whatever it might take, but it is creating the environment for which there are so many downhill issues between children services, the school systems, the safety forces, EMS, it has cost communities millions to respond.
And I know there is this attitude that why would you spend money, why would you not just let them die. It's because every single human on this earth deserves a second

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chance. So do we don't let them die. They are addicted.
Q. And I think you testified earlier that, despite the best efforts, there are individuals who do die --
A. Yes.
Q. -- of prescription opioid overdoses in Summit County, correct?
A. Yes.
Q. And are those overdoses and deaths limited to any particular socioeconomic group?
A. No.
Q. Or limited to any particular gender?
A. No.
MR. NAEEM: Object to form and foundation.
Q. Any particular age?
A. No.
Q. Or any particular ethnicity?
A. No.
Q. And, in fact, this is an issue that I think you testified that you have been deeply involved in as commissioner of public health for Summit County, correct?

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A. Yes.
Q. And is this part of your job, to study and understand the opioid crisis as it exists in Summit County?
A. Yes.
Q. And to help develop programs and solutions to prevent overdose and death and dependency with opioid users?
A. Yes, with staff assistance. I don't do it all. I mean, the staff really are the individuals that work. It's direction, though, to them.
Q. And you had testified earlier that there are also problems in the community with heroin, fentanyl, and carfentanil, correct?
A. Yes.
Q. And in your experience as the commissioner of public health and the work that you have done on these issues, do you believe that the heroin, fentanyl, and carfentanil problems are related to the prescription opioid public health crisis?
MR. NAEEM: Object to foundation.
A. It would be my understanding that illicit drugs became more available as pill

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mills dried up and as prescriptions decreased, so most of the cartels, most of the illicit drug solicitors are business people, and they knew when we created a shortage here and we had all these addicted people that they were going to do all kinds of crazy things to stay addicted, because it is a brain disease.

And you don't just wake up one day and say, oh, today I'm going to be a bad parent, and today I'm not going to take care of my kids. Today I'm going to stop using heroin. It doesn't work like that. You are addicted. It's a brain disease.

And what happens then is, we have seen this over and over and over again, that when the supply dries up and when it decreases, the illicit drugs increase. And now we are seeing dealers who don't make their product as potent, because we are prosecuting them now, and they don't want to go to jail. So we are now seeing polydrug use, mixing other drugs, cocaine, methamphetamine.

Yes, they are individuals that engage in awful behavior, but the group of people that are giving them the business are

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there because of an -- often a very legitimate injury or prescription -- a prescription that took them down a road where they became addicted.

Q. And speaking of other drugs, you were asked some questions about drug abuse generally in the community; do you recall that earlier today?

A. Yes.

Q. And you were asked some questions about other illegal drugs, including cocaine and methamphetamine, correct?

A. Correct.

Q. And I jotted down here that there is some question about a long history of substance abuse in this country, going back to the 1800s; do you recall that?

A. Oh, yes.

Q. Why are prescription opioids alone public health crisis in Summit County, if there are other drug issues that exist in the community as well?

A. First, I think it has been very difficult for us to get our hands around the scope of the problem, because we aren't really

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sure how many individuals are functional addicts out there. And that, down the road, is going to create a whole other set of needs, because individuals can maintain an addiction for a long time, many do for years, and then slowly it will start to unravel.

And they will be engaging in other behaviors, and their lives will sometimes tank, and often some get treatment at that point, other don't. But this is different in that it began because people were going to providers, getting pills, and being told take this for your headaches, and it will be okay, when, in fact, they ended up addicted.

Q. And does the fact that people can be addicted to substances other than prescription opioids mean that prescription opioids are not a public health issue in Summit County?

A. No.

Q. Why not?

A. All of those other drugs we know are illegal. They are illicit, they are illegal, you shouldn't be fooling around with them. Opioids were a totally different -- they

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have a role in society.

I have never taken an opiate, but I can tell you, if I need one and I'm really hurt, I hope I get it. I mean, if you really need pain relief and pain medication, opiates should be available. It was just taken to a whole new level.

Q. And is that what you meant by the oversupply --

A. Yes, because physicians thought it was okay to hand them out to people.

Q. And you were asked a series of questions on a decline in the amount of prescription opioids that are dispensed into Summit County; do you recall that?

A. Yes.

Q. Does the fact that there has been a decline in the amount of prescription opioids dispensed into Summit County mean that prescription opioids are not a public health crisis in Summit County today?

A. No.

Q. And why not?

A. Because I have no idea how many individuals are maintaining an addiction right

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now with still going to a doctor, still getting overprescribed opiates, still getting them and/or sharing them with each other, whatever the case may be. We have no idea, down the road, how far this goes.
Q. And you had testified that one of the jobs of public health is to engage in prevention, correct?
A. Correct.
Q. Is there any way for public health to identify any particular population or particular subpopulation that is likely to turn up as opioid overdoses or opioid deaths or opioid addictions?
MR. NAEEM: Object to form and foundation.
A. No. Not unless I had access to data that told me who -- you know, the communities they lived in or wherever.
That's why we take -- all of our programs, we try to be as mobile and as spread out in the community as we possibly can. I mean, we have done education programs with food services workers, we've gone to business leaders. It's all over. We don't

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differentiate where we have to go for this, because we don't know.
Q. And do you believe that prescription opioids continue to create a public health crisis in Summit County today?
A. Yes.
Q. And that public health crisis that we are talking about, is that something caused only by the diversions or illegal sales of prescription pills?
A. No.
MR. LAVELLE: Object to the form. Go ahead.
Q. Is that prescription opioid public health crisis, is that something that is an issue only related to criminal conduct?
A. No.
Q. Is the prescription opioid public health crisis in Summit County an issue that's only related to so-called pill mills?
MR. LAVELLE: Object to the form of the question.
Q. Is the prescription opioid public health crisis in Summit County caused only by bad doctors?

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A. No.
MR. LAVELLE: Objection to form and foundation.
Q. Is it something that is only caused by bad choices made by addicts.
MR. LAVELLE: Object to the form of the question.
A. No.
Q. Has the county -- has your department undertaken any programs to address the opioid crisis within the county?
A. Yes. Prevention.
Q. And what programs are run through the Summit County Public Health Department?
A. We do alcohol and other drug counseling, but again that came over from the Akron Health Department. We also do needle exchange programs, Summit Safe, we have Project DAWN, we distribute naloxone, we also train police officers in supplying naloxone, so they can use it if they are first on the scene for an unconscious human.
We do quick response teams, where we supply a counselor to go out and visit the homes of those individuals that have overdosed.

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We do fentanyl test strips. I said MAT, medication-assisted treatment. Those are the programs that we have developed.
Q. And have those programs, in your opinion, been effective in mitigating some of the prescription opioid public health crisis that exists in your community?
A. I am hopeful that that's part of it.
Q. And those programs are paid for by, I think you testified, a combination of taxpayer dollars and grants; is that correct?
A. Correct.
Q. Okay. Do you believe that the programs that you have identified alone are enough to address the prescription opioid public health crisis in Summit County?
A. No.
Q. Why not?
A. Because the need. We need to really have additional -- because addiction is a brain disease, and you don't ever live without it.
I had a mother tell me once that when your kid's in recovery and your kid's

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sober, that the addiction is out in the parking lot doing pushups, so it can go back even stronger.

So because we know it's a disease that's hard to manage, like many chronic diseases, we are going to need a lot of medication-assisted therapy to help individuals remain sober, we're going to need recovery houses, we really need to have sober housing for individuals, because, quite frankly, I have talked to so many parents whose child was sober for three years, four years, five years after an opioid addiction, and then overdosed a died.

So prevention isn't just getting -- starting way early and getting resiliency factors and getting kids. It's going to take years to continue this group of caring for, or we're going to continue to have relapse.

Q. If you could describe the opioid epidemic in Summit County in one word, what would it be?

A. Devastating.

MS FITZPATRICK. That's all. Thank you very much.

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THE WITNESS: Thank you.

EXAMINATION OF DONNA SKODA

BY MR. NAEEM:

Q. Ms. Skoda, you were asked -- you were just asked a lot of questions about public health, public health issues generally, and specifically related to use of prescription opioids.

To be clear, you have been health commissioner since 2015, correct?

A. Correct.

Q. All right. And when you were asked questions by the defense side of the table about what happened prior to 2015, you basically said you had no exposure to the opioids as within the health department, or Summit County Public Health, prior to becoming health commissioner in 2015?

A. Well, I knew about them and certainly probably work might have crossed, but it wasn't my direct responsibility. I didn't manage the programs.

Q. So you were a concerned citizen certainly, but no responsibility for Summit County Public Health's response to the opioid

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crisis prior to 2015?

A. Well, I hesitate to say no, because if there was a grant that was being written, I may have helped with the grant. If there were some projects, I may have helped with that. So I might have helped on something or helped work with it, but I wasn't directly focused on that.

Q. Okay. You were asked a series of questions about how to assess public health and needing to do it from, this is my word, a macro perspective rather than looking at individual health records?

A. Correct.

Q. Okay. So, in fact, you don't have the ability to individually assess which of those people who are addicted to illicit drugs like heroin and fentanyl started with a prescription opioid or not?

A. Correct.

Q. And you were asked questions about the socioeconomic demographics of patients who were addicted to opioids. Have you read articles suggesting that the only reason people care about the opioid crisis currently is because it's now affecting primarily white and

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middle or upper class communities?

A. Yes.

MS. FITZPATRICK: Objection.

Q. You've seen those, haven't you?

A. Yes.

Q. You have talking a lot about or -- strike that. I don't want to ask it that way.

You were asked about fentanyl, heroin, and carfentanil and its is increasing prevalence in the community, and you testified that drug cartels were moving in to replace the prescription opioids, because those prescription opioids were becoming harder to get, I'm paraphrasing again, but do you remember that testimony?

A. Yes.

MS. FITZPATRICK: Objection, it misstates testimony.

Q. You certainly don't have any understanding regarding what cartels do or think, do you?

MS. FITZPATRICK: Objection.

A. I have not ever been in a cartel.

Q. Have you ever spoken to any of the Mexican cartels about why they are producing

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fentanyl or carfentanil?
A. No.
Q. So that was speculation on your part; would you agree?
MS. FITZPATRICK: Objection.
A. No. I believe it is in the literature.
Q. Okay. So what literature --
A. And according to the police, police, I would say all of the meetings we have had with Ohio State Patrol or any of those responsible for, I guess, catching them, has made it very clear that those drugs are coming from the Mexican cartel, China is shipping, any number.
Q. Okay. And I understand and I don't dispute with you where that is coming from, but do you have personal knowledge regarding the intent of cartels when they are producing and shipping illegal substances like fentanyl and heroin?
MS. FITZPATRICK: Objection. Misstated her testimony.
A. No.
Q. So again, that was speculation on

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your part regarding what cartels were doing?
MS. FITZPATRICK: Objection. Asked and answered.
A. I'm not speculating.
Q. And again, when you were talking about fentanyl and carfentanil, you said that those patients often started with their addiction with a legitimate prescription. Again, you don't have any data to back that up, do you?
A. I only have the Opiate Task Force has presented, that four out of five started with a prescription drug.
Q. Can we -- do you have Exhibit 14 in front of you?
A. Yes. Okay.
Q. And to be clear, Exhibit 14, this is was a presentation you gave to the Child Family Leadership Exchange, correct?
A. Correct.
Q. That presentation was in September of 2016?
A. Correct.
Q. And the facts and figures page, and again, they are unnumbered, but do you have

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that? You were directed to it by Mr. Salimbene.
A. Yes. The fourth bullet?
Q. The fourth bullet point, "Four and five new heroin users," it starts, correct?
A. Yes.
Q. This, again, this is information from your presentation?
A. Yes.
Q. Is this the information you are citing the four out of five start with prescription opioids?
A. Four and five, it was data put in here because of that. I knew that, yes.
Q. Yeah, and I'm just asking --
A. Yes.
Q. -- there is a citation there, is that --
A. Yes.
Q. -- we talked about four and five a number of times today?
A. Correct.
Q. This is the citation for that, correct?
A. Correct.

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Q. Now, the name of the article is Heroin Use and Heroin Use Risk Behaviors Among Nonmedical Users of Prescription Opioid Pain Relievers?
A. Yes.
Q. Do you know what nonmedical use means?
MS. FITZPATRICK: Objection.
A. Yeah.
Q. What does it mean?
A. That you take the pills to get high, I would assume.
Q. Right. So it's not for medical use, so it is illegitimate, not legitimate use, correct?
MS. FITZPATRICK: Objection.
A. I can't take that from the title. Because, to be honest, when that, "Started out misusing prescription drugs," people can get and then start misusing because they were addicted.
I believe in my heart that people don't ever try to get addicted, and so I think if they start misusing, it's because they are addicted.

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Q. And that wasn't my question. I appreciate your answer. But you cited this for the proposition that four out of five heroin users started with a legitimate prescription. My point is simply, this article doesn't support that, does it?

MS. FITZPATRICK: Objection. Hang on. Can you show her the article?

MR. NAEEM: This is her citation. I can ask her --

MS. FITZPATRICK: Right, but you're asking her based on the title of the article to make an assumption.

MR. NAEEM: Fair.

MS. FITZPATRICK: And you should put the article in front of her.

MR. NAEEM: Speaking objections are not permitted.

MS. FITZPATRICK: Well, then I'll go with asked and answered, because she gave a full answer to this very question.

MR. NAEEM: And her answer prior to my follow-up was that she couldn't say what nonmedical use was.

MS. FITZPATRICK: No. She said she

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didn't agree with your interpretation.

Q. Let's follow up with some questions here.

A. Okay.

Q. Can you cite any article, other than what's in your presentation, for the proposition that four out of five new heroin users started out with a legitimate prescription for opioids?

A. The Opiate Task Force sites that as well. Now, whether or not they used this same source, I don't know.

Q. But to be fair, this citation is in your presentation from 2006, correct?

A. Correct.

Q. As we sit here today, can you tell us whether that article supports your proposition that four out of five heroin users started with a legitimate prescription for opioids?

A. I don't understand what you mean by legitimate. Could you explain that?

Q. Sure. Legitimate means taken as prescribed by a licensed physician and used according to instructions.

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A. Okay. So that's good, but what I think -- I guess where we are just missing on semantical terms, if you start taking that correctly and get addicted, and some people get addicted very quickly, depending on your brain chemistry, how old you are, if you get addicted -- or if you use other substances, but if you get addicted, I think this is saying that you get addicted and start misusing prescription pills.

Now, I understand the title, but I don't remember the article at all, but I understand what you are trying to say to me, but I don't know if I agree.

Q. Okay. Well, I'm asking for your interpretation, right?

A. But my interpretation is that four out of five new heroin users start out misusing prescription pills after they became addicted.

Q. Okay. And so your citation for that and your interpretation is based on that citation, Jones CM, Heroin Use and Heroin Use Risk Behaviors Among Nonmedical Users of Prescription Opioid Relievers?

A. And to me, that nonmedical means

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it's beyond what you were originally given the prescription for.

Q. All I want to do is, when I leave here today --

A. I'm lost.

Q. -- know what the citations are for your proposition that four out of five heroin users started out with a legitimate prescription, because that was your testimony earlier today.

A. So I would look at Jones, and I would look at the Opiate Task Force stuff.

Q. And anything else, as you sit here today, that you can cite for that very specific testimony you gave earlier?

A. No.

Q. You were asked a series of questions, towards the end of your direct, about whether things like criminal activity was the only cause of the crisis, or bad choices of addicts were the only cause; do you remember that?

A. Yes.

MS. FITZPATRICK: Objection.

Q. Certainly they are causes though of

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the crisis?
A. No.
Q. So --
A. Addiction is the cause.
Q. So diversion is not a cause of the crisis?
A. There was a lot of pills that were available, and you're calling it a criminal activity, and it is a criminal activity in law. I mean, people can be charged with taking somebody else's prescription, but people were addicted.
Q. I understand that. I have a simple question though. Is diversion a cause of the current crisis?
MS. FITZPATRICK: Objection. Asked and answered.
A. So you are saying someone who has a prescription and gives it to somebody else?
Q. Right.
A. Is a cause of the problem?
Q. Is it a cause of --
A. It could be.
Q. And the operation of pill mills, is it a cause of the current opioid crisis in

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Summit County?
MS. FITZPATRICK: Objection.
A. I don't know that, because I don't know how many pill mills were here.
Q. Criminal activity, is that a cause of the current opioid crisis?
MS. FITZPATRICK: Objection.
A. What do you mean by, "Criminal activity"?
Q. Well, that was the question you were asked. I'm assuming it is the provision of heroin and fentanyl --
A. Oh, oh, oh.
Q. -- from outside sources into Summit County.
A. No.
Q. Not at all? So if there was no heroin and fentanyl in Summit County --
A. I think it brought to light an underlying problem that was just brewing out there.
Q. So to be clear, the manufacturers of illicit heroin and fentanyl bear no responsibility for the current crisis in Summit County?

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MS. FITZPATRICK: Objection.
A. The manufacturers of those, you mean, the street dealers?
Q. Sure. The people who manufacture fentanyl in China. They bear no --
A. Yes, they are guilty of manufacturing it, but they would not have been able to sell their wares to anyone if these individuals weren't addicted.
And many of them got addicted by other ways that weren't related to going out and finding street heroin. People just don't just start going out and getting street heroin. There is a long pathway.
Q. And what is your citation for no one does that?
A. It would be -- it's experience. It's personal times I have spent with -- they wouldn't even know.
I spent a great deal of time with individuals who are drug users, homeless drug users. It's a -- and often they are individuals that people don't like, because the brain disease takes over, and they do all kinds of horrible things to support that habit. But

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really, underneath it all, they are really good people that just need support and help.
So I don't really have a formal reference that no one, but in my wildest dream, I could not think of somebody going out for the first time ever using a drug and getting heroin. It just doesn't happen.
Q. Okay. Well, so let's clarify then. Did all heroin users start by using prescription opioids?
MS. FITZPATRICK: Objection.
A. I don't know that.
Q. Certainly we know that there were prior epidemics of opioid addiction, for example, after the Vietnam War?
A. Yes.
Q. They weren't using prescription opioids, were they?
A. No.
Q. There were opioid addiction crisis in the early 1900s?
A. Yes.
Q. There weren't any prescription opioids back then, was there?
MS. FITZPATRICK: Objection.

A. I'm not sure. I don't know if it was prescription, but they were not the manufactured, but they were given certain -- there was a belief -- they gave it to them because they didn't have anything else, so that was used, yeah.

Q. So even if we just limit our discussion to people who use heroin based on their prior use of other substances, illegal substances, it's not just prescription opioids, it could have been marijuana, it could have been alcohol, it could have been many other substances that led to their use of heroin?

MS. FITZPATRICK: Objection. Form.

A. It could be.

MR. NAEEM: No further questions.

MS. FITZPATRICK: Nothing further.

THE VIDEOGRAPHER: Off the record 6:00 p.m.

(Deposition concluded at 6:00 p.m.)

- - - - -

Whereupon, counsel was requested to give instruction regarding the witness's review of the transcript pursuant to the Civil Rules.

SIGNATURE:

Transcript review was requested pursuant to the applicable Rules of Civil Procedure.

TRANSCRIPT DELIVERY:

Counsel was requested to give instruction regarding delivery date of transcript.

REPORTER'S CERTIFICATE

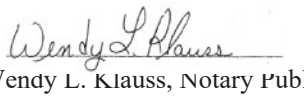
The State of Ohio,)
SS:
County of Cuyahoga.)

I, Wendy L. Klauss, a Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within named witness, DONNA SKODA, was by me first duly sworn to testify the truth, the whole truth and nothing but the truth in the cause aforesaid; that the testimony then given by the above-referenced witness was by me reduced to stenotypy in the presence of said witness; afterwards transcribed, and that the foregoing is a true and correct transcription of the testimony so given by the above-referenced witness.

I do further certify that this deposition was taken at the time and place in the foregoing caption specified and was completed without adjournment.

I do further certify that I am not a relative, counsel or attorney for either party, or otherwise interested in the event of this action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, on this 17th day of August, 2018.



Wendy L. Klauss, Notary Public
within and for the State of Ohio

My commission expires July 13, 2019.

Veritext Legal Solutions
1100 Superior Ave
Suite 1820
Cleveland, Ohio 44114
Phone: 216-523-1313

August 17, 2018

To: Anne Kearse

Case Name: In Re: National Prescription Opiate Litigation v.

Veritext Reference Number: 2987504

Witness: Donna Skoda Deposition Date: 8/14/2018

Dear Sir/Madam:

Enclosed please find a deposition transcript. Please have the witness review the transcript and note any changes or corrections on the included errata sheet, indicating the page, line number, change, and the reason for the change. Have the witness' signature notarized and forward the completed page(s) back to us at the Production address shown above, or email to production-midwest@veritext.com.

If the errata is not returned within thirty days of your receipt of this letter, the reading and signing will be deemed waived.

Sincerely,
Production Department

NO NOTARY REQUIRED IN CA

DEPOSITION REVIEW
CERTIFICATION OF WITNESS

ASSIGNMENT REFERENCE NO: 2987504
CASE NAME: In Re: National Prescription Opiate Litigation v.
DATE OF DEPOSITION: 8/14/2018
WITNESS' NAME: Donna Skoda

In accordance with the Rules of Civil Procedure, I have read the entire transcript of my testimony or it has been read to me.

I have made no changes to the testimony as transcribed by the court reporter.

_____ _____
Date Donna Skoda

Sworn to and subscribed before me, a Notary Public in and for the State and County, the referenced witness did personally appear and acknowledge that:

They have read the transcript;
They signed the foregoing Sworn Statement; and
Their execution of this Statement is of their free act and deed.

I have affixed my name and official seal

this _____ day of_____, 20____.

_____
Notary Public

_____
Commission Expiration Date

DEPOSITION REVIEW
CERTIFICATION OF WITNESS

ASSIGNMENT REFERENCE NO: 2987504
CASE NAME: In Re: National Prescription Opiate Litigation v.
DATE OF DEPOSITION: 8/14/2018
WITNESS' NAME: Donna Skoda

In accordance with the Rules of Civil Procedure, I have read the entire transcript of my testimony or it has been read to me.

I have listed my changes on the attached Errata Sheet, listing page and line numbers as well as the reason(s) for the change(s).

I request that these changes be entered as part of the record of my testimony.

I have executed the Errata Sheet, as well as this Certificate, and request and authorize that both be appended to the transcript of my testimony and be incorporated therein.

_____ _____
Date Donna Skoda

Sworn to and subscribed before me, a Notary Public in and for the State and County, the referenced witness did personally appear and acknowledge that:

They have read the transcript;
They have listed all of their corrections in the appended Errata Sheet;
They signed the foregoing Sworn Statement; and
Their execution of this Statement is of their free act and deed.

I have affixed my name and official seal

this _____ day of_____, 20____.

_____
Notary Public

_____
Commission Expiration Date

ERRATA SHEET
VERITEXT LEGAL SOLUTIONS MIDWEST
ASSIGNMENT NO: 8/14/2018

PAGE/LINE(S) / CHANGE /REASON

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_____ _____
Date Donna Skoda

SUBSCRIBED AND SWORN TO BEFORE ME THIS _____
DAY OF _____, 20_____ .

_____
Notary Public

_____
Commission Expiration Date

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Federal Rules of Civil Procedure

Rule 30

(e) Review By the Witness; Changes.

(1) Review; Statement of Changes. On request by the deponent or a party before the deposition is completed, the deponent must be allowed 30 days after being notified by the officer that the transcript or recording is available in which:

(A) to review the transcript or recording; and

(B) if there are changes in form or substance, to sign a statement listing the changes and the reasons for making them.

(2) Changes Indicated in the Officer's Certificate. The officer must note in the certificate prescribed by Rule 30(f)(1) whether a review was requested and, if so, must attach any changes the deponent makes during the 30-day period.

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VERITEXT LEGAL SOLUTIONS
COMPANY CERTIFICATE AND DISCLOSURE STATEMENT

Veritext Legal Solutions represents that the foregoing transcript is a true, correct and complete transcript of the colloquies, questions and answers as submitted by the court reporter. Veritext Legal Solutions further represents that the attached exhibits, if any, are true, correct and complete documents as submitted by the court reporter and/or attorneys in relation to this deposition and that the documents were processed in accordance with our litigation support and production standards.

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